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ORIGINAL ARTICLES

SOME LATE OBSERVATIONS ON FECAL EXAMINATION.

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The researches of the last years on the subject of intestinal diseases has been carried so far as to enable us to speak of a functional diagnosis of intestinal diseases just as we do in gastric diseases. It is chiefly the merit of Adolf Schmidt in Halle, to have worked out methods for a functional diagnosis, and to have systematized the whole subject. In the diagnosis of intestinal diseases we meet with far more difficulties than in gastric diseases. The stomach can be investigated very easily by means of a tube and other instruments. In the diagnosis of intestinal diseases, however, our field of work is limited almost to the examination of the feces. This has, however, been elaborated by Schmidt so thoroughly as to furnish us a fundament for an exact functional diagnosis. For such a diagnosis we require, according to Schmidt:

1. The examination of a normal feces, obtained after a test meal.
2. The choice of a method which is as much as possible analogous to that of gastric diseases. We have to get information about the function of the stomach, then to test the function of the intestines, by examining the undigested residues of food, as well as pathologic products, as mucus, pus, blood, parasites, etc. We must try to localize disorders of motility, secretion, or absorption.

The test-meal. In general the properties of a test-meal for the functional investigation of the intestines should be so that it can be taken by healthy and sick people. It has to contain the three constituents of our nourishment in a due proportion and it should be as much as possible free from ashes and still contain enough ashes as to be able to stimulate peristalsis sufficiently.

Schmidt prescribes such a diet as follows:

Milk, 1.5 liters (2¾ pints.)
Zweiback, 100 grams (3 ounces well dried toast).
2 eggs.
Butter, 50 grams (1½ ounces).
Beef, very rare, or scraped beef, 125 gram (¼ pound).
Potatoes, 190 grams (6 ounces).
Gruel, made from 60 grams oat meal (2 1-3 ounces).
Sugar, 20 grams (½ ounce).

This may be given as follows:

Breakfast: 2 eggs, half of the amount of toast and butter, 2 glasses of milk, oat meal, sugar.
Dinner: The steak and potatoes, 1-3 of the amount of toast and butter, 1½ glasses of milk.
Supper: 2 glasses of milk, remainder of toast and butter.

Although the individual ingests 1.5 liter of milk, 100 gr. toast, 2 eggs, 50 g. butter, 125 g. beef, 190 g. potatoes and 80 g. gruel, this is equivalent to 110 g. albumen, 105 g. fat and 200 g. carbohydrates, or 2247 calories.

This test is taken for a least three days in succession, until we are sure that the stool is solely originating from such a diet.

If we wish to determine the time which it takes for the feces to pass the intestinal tract, we have the patient take some carmine. As soon as feces appears with a red color we can estimate the time of the passage of a given amount of food.

The Examination of the Feces. The microscopic examination is very often sufficient for a functional diagnosis. The color of a normal stool is brown. It is a lighter brown if milk has been taken, dark brown after taking cocoa. Pathognomonic colors are tar color (blood in the feces) and clay color (fat).

The odor of a normal stool is never pungent. In pathologic conditions we notice an odor like butyric acid, or a putrid odor.

After this superficial inspection we spread the stool, after having stirred it thoroughly, on a china plate, and after adding some distilled water we stir it up to a cauce-like consistency (10 minutes). As a whole a normal stool should then be quite homogenous. Some particles of vegetables or fruits are of no great significance. They may originate from the food taken previously to the test-meal.

In pathologic conditions we find:

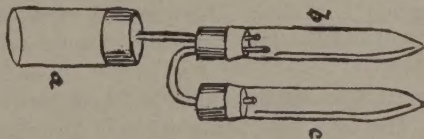
(a) Residues of food: 1. Connective tissue and tendons, originating from the mashed beef. These residues have a white-yellow color and a thread-like shape. Such a thread treated with a drop of acetic acid is examined microscopically. If it is connective tissue the thread-like structure disappears. If fibres of

tendon or of connective tissue are numerous we have to deal with a disorder of gastric digestion. 2. Muscles: They look like brown rods, can be mashed by pressure; microscopically we notice the muscular structure; residues of muscle indicate a disorder of intestinal digestion. 3. Potatoes: They appear as sago-like, glassy, transparent bodies; they project from the level of the feces; microscopically we find with iodine the characteristic blue color of starch. 4. Fat: Recognized by the light color and the clay-like consistency.

(b) Accessory contents: 1. Mucus. 2. Crystals of phosphorus, ammonia-magnesium phosphate; are mostly found in putrid stools; they are easily recognized by their coffin-shape.

For the microscopic investigation of the feces we prepare three slides. One specimen is examined without adding anything; to the second slide we add a drop of 30 per cent. acetic acid and heat it over a flame until it begins to boil; to the third slide we add a drop of iodine-potassium-iodide solution.

The microscopic picture of normal feces shows in the first slide an accumulation of granules, globules and bacteria. We notice some few



Fermentation tube, according to Strassburger.

muscle fibres, recognizable by their striated structure. Lumps of fatty acid lime of a yellow color, unstained soaps, scanty potato cells, scanty residues of the shells of oat, eventually residues of cocoa.

In the second slide we have melted the fatty acid by heat. We see the whole slide scattered over with fatty acid. The third slide is colored brown, the potato cells may show a faint violet color, however no blue color.

In pathologic cases we may find:

1. In the first slide:

- (a) Pieces of muscles, mostly well preserved.
- (b) Needles of fatty acid crystals and soaps.
- (c) Globules of neutral fat.
- (d) Copious amounts of potato cells with more or less well preserved granules of starch.
- (e) Eggs of parasites, connective tissue, mucus, pus, etc.

2. In the second slide (prepared with acetic-acid):

Copious lumps of fatty acid.

3. In the iodine slide:

- (a) Starch, colored blue.
- (b) Spores of fungi, bacilli, colored blue.
- (c) Yeast cells (colored yellow), bundles of sarcina and other microorganisms (lactic acid bacilli).

In the chemical investigation of the feces we have to consider:

- (a) The reaction to litmus-paper. A normal stool gives a neutral reaction or at most slightly acid or alkaline.
- (b) The test with corrosive sublimate. If we add sublimate to the feces, stir it up and allow it to set, the normal feces will on the next day be colored red (hydrobilirubin), whereas a green color is indicative of bilirubin.
- (c) The fermentation test in the incubator. A portion of the feces is brought into a fermentation tube and mixed and stirred with water; the tube is left in the incubator for 24 hours at a temperature of 37° C.

In a normal stool practically no gas is developed. If fermentation takes place and the feces react distinctly acid, we have to deal with a carbohydrate fermentation. If the feces have become alkaline, an albuminous putrefaction is present. In the case of a carbohydrate fermentation the contents of the tube smell like butyric acid. In putrefaction the odor is foul.

A very practical fermentation tube has been described by Strassburger (Fig. 1). The feces is put into the part A, it is closed by a rubber-stopper, without allowing air-bubbles to remain in A. The tube B is filled with water; the tube C being open at the top, remains empty. If gas is developed, the water in B is driven into C. From the level of the water in C we can estimate the amount of gas that has been developed. The investigation for blood is carried out in the usual way.

The examination for bacteria does not strictly belong to a functional diagnosis. For a functional diagnosis it is of the greatest importance to know the significance of the various constituents of the feces.

1. *Mucus*: Mucus in the feces is always indicative of inflammatory conditions of the intestinal tract. There are, however, two exceptions; in constipation the hard scybala may sometimes be covered with mucus, without a catarrh being present. The second exception is a mucus colic, in which a profuse hypersecretion of mucus may be found.

The mucus is for the greatest part originating from the large intestine.

2. *Bile bilirubin*: Giving a green color to the stool is always pathognomonic. It is indicative of a too rapid passage of the intestinal contents. Such a stool is always colored green by adding Hg Cl₂. Normal feces is colored red by Hg Cl₂. If neither a red nor a green color appears, no hydrobilirubin is present in the feces. Consequently no bile was

present in the intestines. This would indicate an obstruction of the gall-ducts.

3. *Fat*: Fat is in every stool. It is our task to determine whether considerable amounts of fat are present. A fatty stool shows a clay-like consistency; the reaction is acid. Fatty stools are found: (a) In cases of a deficient secretion of bile or in an obstruction of the biliary ducts. (b) In disorders of the pancreatic secretion. (c) In disorders of the intestinal digestion.

4. *Residues of meat*: (a) Connective tissue; as only the gastric juice is able to digest raw connective tissue the presence of the latter is indicative of a gastric disease. (b) Muscle; the presence of muscle-fibres is indicative of an affection of the small intestine. The stomach does not play an important part in the digestion of muscle-fibres. The greatest part of the latter is digested in the intestines. Now several intestinal secretions are active in the digestion of muscle-fibres. A defective digestion of muscle-fibres may be due to a lack of pancreatic secretion, activating enterokinase of the secretion of the small intestine, to an increase of peristalsis, or finally to a disturbance of absorption. The appearance of muscle-fibres in the feces does not allow any conclusion as to the true nature of the disease. We can, however, state positively that the small intestine is involved.

5. *Residues of carbohydrate*. The presence of starch indicates an affection of the small intestine.

The functional diagnosis has up to date unfortunately failed to give a sufficient method for testing the motility. Probably the most reliable method is the use of the Röntgen rays after feeding a food mixed with bismuth subnitrate. It is however, as we have seen, pretty elaborate in investigating the secretory conditions. For the secretion of the pancreas there are in addition three direct methods, viz: Sahli's method with glutoid capsules, Schmidt's nuclear test, and the urine test of Cammidge.

1. *The glutoid test of Sahli*. If gelatine capsules are treated with formaldehyd they are hardened and thus protected against the digestive action of the gastric juice. Such capsules, so-called glutoid capsules, are filled with iodoform. As soon as the pancreatic juice opens the capsules, iodoform is resorbed very rapidly and the saliva of the patient shows at once an iodine reaction. The disadvantage of this test is the fact that the capsules are sometimes even too hard for the pancreatic juice. (*Deutsche med. Wochenschrift*, 1899, No. 1.)

2. *The nuclear test of Schmidt*. (*Kongress f. innere Medicin* 21, 1904, p. 335). This test is based upon the fact that nuclei of cells are only digested by the pancreatic juice, however not by the gastric juice. Schmidt has the patient eat a small piece of meat wrapped in a small bag of cotton gauze. This bag is easily found in the feces and the contents of it is examined for nuclei. Einhorn (*Archiv f. Verdauungs-krankheiten* 13, 1907, p. 475) recommends a piece of thymus instead

of meat, since thymus is very rich in nuclei and does not necessitate a troublesome hardening and staining of the preparation.

3. *Cambridge's reaction*. (*The Lancet*, 1904, 19 111, July, 1905). This test is based upon the transition of certain products of breaking down of pancreatic tissue into the urine. The method is, however, too complicated for practical purposes.

The elaborate system of functional diagnosis worked out by Schmidt has furnished a working basis of a pathology of intestinal diseases.

PLACENTA PREVIA.*

By R. T. HENDERSON, M. D., Jackson, Mo.

Every physician doing a general practice dreads to encounter certain disorders. Only a few years ago the call to attend a case of croup was an unwelcome one, for the stoutest heart quailed at the thought of a midnight encounter with the relentless strangler, who, despite every effort of the doctor, so often choked out a precious young life—breaking at the same time some mother's heart. Few of the older men here can not recall some experience of this kind, some hour between midnight and dawn, when, with a woman's pleading for help twisting their heart-strings and a suffering child's gasps growing fainter and less frequent to their ear, they have questioned the efficacy of medicine, and determined to adopt some calling less productive of premature gray hairs. To-day the doctor fears croup no more than he does measles—the discovery of iodized calcium providing him with a weapon which, resolutely and skillfully wielded, will rout the disease nine times out of ten. Eclampsia, with its sudden and terrorizing convulsions, has perhaps caused fully as much dismay as croup. The young accoucher suddenly confronted with a typical seizure has undoubtedly wished fervently that he could grab his hat and run, or having sent for counsel (like the hero of Waterloo) has prayed earnestly that reinforcements, or the child, would come. And even to-day the experienced and fully equipped obstetrician grows grave when eclamptic conditions present; for, occasionally, despite the most scientific and heroic treatment, death wins the fight. However, the pathologist and the chemist have lately thrown such a flood of light upon the intricacies of the body chemistry, that we are able almost positively to prevent the occurrence of eclampsia; provided, of course, the woman places herself in our hands early enough and takes enough interest in her

*Read at the meeting of the Cape Girardeau County Medical Society, November, 1909.

own welfare to report with a specimen of her urine every three or four weeks.

Preventive medicine, we are beginning to realize, is, after all, well worth our most earnest attention, but there are conditions which cannot even be suspected and unhappily one of the most disastrous—placenta previa—often first makes its existence evident by a furious hemorrhage, which, unchecked, may destroy the life of mother and child within ten minutes. Fortunately this is not a common disorder, but one can never tell when he may encounter a misplaced placenta, and it behooves every physician to not only know what can be done under the circumstances but to have a definite idea of the procedure he will adopt should it be his illfortune to meet with a case. I recall the experiences of a friend, as follows: "Being sent for, some years ago to go to a house not far distant from my office, the boy who came for me urging extreme haste; indeed, so anxious was he that I should go, that he begged me not to wait to get any instruments or medicines, not even my hat. All he had to say was, 'Hurry, Doctor, please do hurry, Ma's dying, I know; Oh! won't you *please* run.' He couldn't tell me just what form of disaster had overtaken his mother, but his bearing convinced me that affairs were urgent. So, grabbing my utility satchel and a pocket case of emergency remedies, I *ran*. On entering the room I found a woman of thirty stretched on the bed, from which blood was running to the floor. This was uncarpeted, and the thin red stream had already covered half the distance between the foot of the bed and the door. A glance at the face showed fearful exsanguination; the woman could not speak and the barest flutter of the heart was discernable. I threw off my coat, turned up my sleeves and pouring into the hollow of my hand a few drams of ethereal tincture of soap entered the vagina, and acquainted myself with uterine conditions. I found a partial dilation—the bunched fingers were easily inserted—a centrally implanted placenta and a breech presentation (at least I determined that it was a breech, and two minutes later on penetrating the placenta and rupturing the membranes I confirmed the diagnosis). I had no assistant, the woman was unconscious; the room was cold (I was not), and in answer to my request for boiling water, the boy called from the outside that 'he'd go to the next house and get some.' Just as I had brought down one foot he arrived with the water in a pint pitcher, and a neighbor woman. She, upon seeing the condition of things promptly shrieked and fled. Five minutes later, when two legs were down, and I was wondering whether I had one death or two on my hands, two more women appeared and one of them had common sense enough to turn in and help *do* things. Between us we later on delivered a female child, who is now very much alive, and removed a very large thin placenta (placenta membranacia), finally cleaning up the woman and removing her to another bed, where two hours later she showed signs of returning vitality." The loss of blood in this case was enormous, and I am quite sure that life was maintained only by the

copious injections of saline solution and free exhibition of atropine and strychnine. A few moments' delay would have resulted in the death of both mother and child; and any hesitancy, or attempt at cleaning up or tamponing would have been fatal also. In desperate cases of this kind one must act first and think while acting. Moreover there must be no mistakes, the right thing and only the right thing under the circumstances existent can save the situation. All cases of placenta previa are not quite as disturbing as this, but each and every one calls for skill, presence of mind and prompt action.

I will not attempt to describe the varieties of placenta previa further than to say that implantation in the lower uterine segment may cause the entire occlusion of the os internum (placenta previa centralis) or merely partially obtrude upon that orifice (placenta previa lateralis). The textbooks state that the marginal form is encountered eight times where the central variety occurs once. One observer records one central to twenty-five marginal; another twenty-six central to one hundred and fifteen lateral.

It is impossible, of course, to estimate the number of premature births which are caused by improper placental growth, but leaving these out of the question it is safe to estimate one case of placenta previa in every seven hundred deliveries, at term. In maternity hospital, where ill-nourished women are delivered, the proportion is much greater.

Some men may practice their entire lives and never see a case, or at least a severe one; again the very first case the young doctor may be called to, may turn out to be placenta previa centralis. Usually, in order to correct or control a pathological condition it is necessary that we understand fully its etiology. "The right remedy for the condition present" is a maxim which should be faithfully adhered to, but in this instance we must be content with the knowledge that for some reason the placenta occupies the lower instead of the upper uterine segment, and its mass therefore offers a more or less formidable obstruction to the descent of the fœtus. Moreover, as dilation occurs and downward pressure increases, the placental adhesions are loosened and hemorrhage results. Not infrequently a warning hemorrhage occurs after the fifth month, and in some instances women have bled copiously at short intervals without realizing that anything was seriously amiss. Such patients are apt to cause, later on, a very great deal of trouble to the attendant physician.

It is necessary that we distinguish the hemorrhage which results from placenta previa from any bleeding having its origin in an injured, partially detached, but normally situated placenta. In the first instance the hemorrhage may be unavoidable, for at some time, more or less abnormal loss of blood must result; in the latter case, the existent hemorrhage, once controlled, no further trouble need occur. This is an accidental hemorrhage.

The idea that the abnormal implantation is due to the falling of the placenta from its usual site early in the pregnancy has been entirely ex-

ploded and we now know that the ovum becomes attached in the lower portion of the uterine cavity growing there often, just as successfully as in the proper location. Further, there may be reflexal placental formation, with degeneration changes in the reflexa and adjacent villi. This condition has been minutely described by Peters; and Webster in his excellent chapter on placenta previa, deals very fully with the subject. This condition is of interest, for the reason that as changes in the pregnant uterus take place the degenerated reflexa is apt to give way, hemorrhage and abortion resulting. It is more than likely that a great many abortions and miscarriages may be attributed to this condition. In my opinion a reflexal placenta previa rarely persists till term; we have then to deal with an entirely normal, but faultily placed placenta, the ovum having been fertilized in, and becomes attached to the lower uterine segment. To the obstetrician, interested chiefly in the practical side of the subject, it matters little whether the mal-position be central, marginal or lateral, if intractable hemorrhage occurs early in the pregnancy the uterus must be emptied; if, however, the woman proceeds to term, or thereabout, before hemorrhage sets in, the object in view is the safe delivery of the woman and (if possible) a living child.

Recurrent hemorrhages during the last nine weeks of pregnancy may be regarded as presumptive evidence of a placenta previa, but as has been stated, occasionally the pregnancy progresses normally till dilatation, and expulsion pains set in (and in these cases we meet with serious hemorrhages), but even more appalling conditions present when suddenly, some six or eight weeks before term (often at night and without known cause), the pregnant woman finds herself bleeding profusely. The slightest movements augment the flow, and not infrequently the patient is almost exsanguinated before medical aid can be secured. Again, a sharp hemorrhage may follow some slight exertion, the flow ceasing in a few minutes or dwindling to a mere dribble which may persist for days. Some women expect more or less hemorrhage during the last two months of pregnancy, and only send for a doctor if the flow becomes alarming. It is a fact that a tendency to placenta previa runs in families, and a friend informs me that he has records of almost fatal hemorrhages occurring in the persons of a mother and two daughters early in the eighth month. The mother had borne eight prior children without difficulty; the elder daughter was the mother of one child normally delivered; the younger was bearing her first infant. She has never conceived since. In every case the hemorrhage came on without warning and in the middle of the night. Fortunately, however, multipara are more likely to suffer from this disorder; and having experienced, they realize the gravity of the symptom and send for aid promptly.

The mortality accompanying placenta previa necessarily varies greatly. Occurring during the first six months, the hemorrhage, though it may be severe, is rarely fatal; the fetus, unfortunately, is however rarely saved. Nearing or at term, prompt and skillful intervention means everything;

hence, in country practice the maternal mortality is often high, the physician being unable to reach the patient before she becomes exsanguinated. In such cases the child often survives. In cities and more populous localities the maternal mortality does not exceed twenty-five per cent., though one authority gives it as fifty per cent. The average mortality among American women, hospital inmates excepted, may be placed at thirty-five per cent., the infant mortality probably does not exceed fifteen per cent.

The most interesting feature of the subject to the practitioner is treatment. If a woman is pregnant and experiences a sudden hemorrhage, it is absolutely essential that an examination be promptly made. The extent of the bleeding will serve to indicate the degree of haste necessary. If the flow is steady and considerable blood has already been lost, rapidly clean the hands, wash off the external genitalia, and assure yourself of the uterine conditions. If the os is dilated at all—and it usually is—the placenta can be easily felt; moreover ballotment can not be obtained, and the fetal parts are not distinguishable. Under such circumstances the diagnosis of placenta previa may be positively made. Where the implantation is central the peculiar boggy mass will be felt in the posterior and anterior fornices; if it is marginal, however, only one fornix will present the abnormality; in some cases, indeed, where the attachment is markedly posterior, the finger fails to detect the placenta at all until inserted well within the internal os.

Personally, I am not particularly anxious to make a thorough examination in even the less serious cases; infection is very apt to follow undue handling, and it matters very little to the accoucher just where the placenta site is, provided it encroaches upon the lower segment and obstructs delivery.

The bleeding during examination (which need not take many minutes or seconds in the worst cases) will continue, and as the physician works he should ask questions, ascertaining, if possible, the date of expected confinement. If pregnancy has advanced to such a stage that the fetus is viable it is necessary to determine whether it is best to dilate and deliver, or adopt palliative measures. If the termination of the pregnancy would inevitably result in the death of the fetus it is well to try tamponade, rest and elevation of the pelvis; provided, of course, the hemorrhage is not too serious and the woman is so situated as to receive proper care and prompt attention if the bleeding persists. It is in these early hemorrhages that experience and skill mean much. When the younger and inexperienced man would proceed to empty the uterus (at the expense of the child's life and considerable risk to the mother) the seasoned obstetrician tampons snugly, elevates the hips, enjoins absolute quiet and administers small doses of hyoscine and morphine, with perhaps hydrastin. Not infrequently the woman so treated goes along with perhaps slight or more severe hemorrhage at intervals, to or near term, being delivered finally of a living child. I would like to caution

here against the use of astringents. We have to deal not with a local relaxation of abnormal blood conditions, but with a distinct tearing of tissues—intrauterine. It is not desirable to cause the formation of a cervical clot, neither should we dam back the blood into the uterine cavity. Our aim should be to relieve the condition which causes the hemorrhage; this we may often do by packing snugly the fornices with wool or soft gauze (I prefer the long wool strips which can be obtained in these days), raising the pelvis above the thorax, and reducing the blood pressure in the affected area. No drug known to me exerts so positive and prompt an effect as atropine, although hyoscine and morphine maintain the effect and also tranquilize the patient. I give gr. 1/250 of atropine as a first step in nearly every case, substituting hyoscine, morphine and cactin in fairly controllable cases when I propose to empty the uterus at once. In terrific hemorrhages the atropine always.

The imaginary case we have on hand has not reached term and the hemorrhage, though severe, is not essentially dangerous. We decide to plug and await developments. Wool strips we may not have on hand. So we take strips of antiseptic gauze or clean old linen, and firmly pack about the cervix well up into the fornices, and continue until the vagina is snugly filled. If the strips are buttered with vaseline and dusted with an alkaline antiseptic powder we can leave them in longer, and have less fear of sepsis. Some intelligent person must be left in charge of the woman and receive instructions to send for us if any quantity of blood escapes from the vaginal orifice, or pallor and faintness are noted. If hemorrhage persists in such a case we will have to deliver. On the other hand, if in eight or ten hours things are in a satisfactory condition, we should remove the packing very gently and replug, keeping the woman on her back for several days; tampon afresh every 24 hours. If after a week hemorrhage is absent we may allow some exercise, but exertion should be absolutely forbidden. It is a question whether medicines can be of much service at this stage, but I always order hydrastine, aletrin and caulophyllin, gr. 1/6 of each, every four hours, and my results warrant the procedure. I also apply a snugly-fitting abdominal binder, so gored and stiffened as to lift up the uterus and its contents. I keep a sharp lookout in such cases and always instruct the family to send at once for the nearest physician (with whom I try to be in touch) if hemorrhage recurs and I am not immediately available. Moreover, where it is possible, I have a nurse always in the house and she tampons, administers atropine and elevates the patient's pelvis at the first sign of trouble. In all such cases it is essential that the woman have highly nutritious, easily digested food and keep her bowels open by the use of salines. I might state here that I invariably place the woman in the knee-chest, or lithotomy, position when tamponing—it is not a bad idea to have her adopt this position the minute hemorrhage is experienced. I have reason to believe that I have saved two lives, at least, by ordering the prompt assumption of this position. In one case the woman began to flood while

removing a pan of bread from a low oven; she dropped the pan, assumed the knee-chest position and her sister (who acted as nurse) promptly called me up and tamponed. When I arrived bleeding was profuse, but I delivered a live child within the hour, and after a tedious convalescence the mother recovered.

Now I will consider the more terrifying and serious type of hemorrhage which occurs when a healthy but abnormally located placenta begins to separate from the uterine wall, owing to descent of the fetus or dilation of the lower segment. I have already stated that a reflexed placenta previa makes its existence evident earlier. If we have had prior hemorrhage we shall be prepared; but if, as often happens, we are rushed for the first time to the bedside of a woman who is flooding furiously, we shall have to do the best we can—and this ought to be a good deal. Assured that the fetus is viable and pains present, we had best empty the uterus just as quickly as we can, for every minute's hemorrhage means much to the woman. If dilation is slight it is in my opinion, useless to tampon in the hope that we may secure better conditions, for at this stage such procedures will often not check the hemorrhage, and rarely hasten dilation. We must be as clean as we can (losing no time in the refinements of asepsis) and proceed to dilate. If we can not, we must use the metal dilators, or the Champetier or Ribes' bag. Personally I have never used the latter contrivance, and consider it more suited to hospital than ordinary practice. However, it has its ardent admirers. A most efficient dilator with three separate sets of tips has quite recently been introduced by Prof. DeWees. In this instrument the four blades are inserted closed, and an equal distension is rapidly secured by turning a milled head on the handle. Full dilation can be secured with this instrument in five to ten minutes. Laceration can hardly occur, as the blades are curved at the extremity, broad and rounded. Dilatation must be done if the cervical opening will not admit the fingers easily. Sometimes we have no dilators, no Champetier bag, or anything beyond our digits, and therefore we should know how to use them. First, stretch with the two fingers, then insert the thumb, and when all possible room has been gained, slip in the fourth and finally the little finger, gradually spreading the tissues till the entire hand can be easily inserted. If it be possible to slip past the edges of the placenta, do so; if not, penetrate it, but do not rupture the membranes beyond, as the amniotic fluid makes version difficult. These procedures are not required if the attendant possesses a Barnes or de Ribes bag, and is sufficiently familiar with their use to plug the cervical canal effectively till dilatation is sufficiently advanced. I need not dwell here upon the method of using either appliance as every text-book gives the proper technique. Dilatation being secured, with one hand pressure should be made upon the fundus, so that the presenting part of the fetus can be surely recognized. If the breech be encountered the fingers are thrust through the membranes, and one or both feet seized; steady traction is then maintained, the oncoming

buttocks serving as a most efficient plug; in very many cases, delivery proceeds without further undue hemorrhage. The method of delivering the fetus so presented is of course known to you all. It may be worth while to caution, however, against carelessness; not for a moment should the traction be relaxed; and it is advisable to have an assistant make pressure steadily—especially during the pains—upon the upper pole. It is not desirable either to lose much time searching for both feet; if only one is immediately available grasp it and bring it down through the cervix; the other extremity will follow later, or can be secured; at the moment, we are most desirous of making pressure upon the bleeding placental site. With patience (and maintained pressure) we may feel fairly sure of delivering the child alive. If we have to deal with a transverse presentation, and we will usually discover the existence of this condition by abdominal palpation, we must insert the one hand through the placental tissues but not through the membrane, and perform version as rapidly as may be. The external hand aids greatly by pushing upward and backward the undesired pole. I invariably try to bring down the feet. As soon as proper position has been secured, rupture, grasp a foot or the feet, and proceed as already suggested. Not infrequently there is considerable difficulty in delivering the after-coming head; here again, however, patience works wonders, especially if two fingers are insinuated up along the neck and made to pull back the cervical tissues. This difficulty is not encountered when the faulty location of the placenta is made evident only after normal labor has set in. It is my opinion that by far the safest course to pursue in the class of cases under discussion is, to dilate—digitally or with instruments—until the hand can be inserted into the amniotic cavity, to grasp then a foot, bring down one or both legs, and wait for nature (aided somewhat by the attending physician) to do the rest. After this, too much haste is almost as undesirable as lethargy earlier, for it is not impossible to tear the cervical—or even the lower uterine—tissues severely by too persistent or too rapid extraction.

It might aid some to remember that the first thing to do in all cases of placenta previa is, to ascertain the extent of cervical dilatation. If bleeding occurs earlier than the eighth month, or if the os will only admit one finger, plug and await developments. If the woman is near term but os is undilated, plug; apply in each case a tight binder and elevate hips. If you can get two fingers through the internal os, dilate digitally till you can do an internal version—or if you can do a Hick's bipolar version, do it without dilating further. In each case you bring down the feet and thus compress the bleeding area, thus saving the woman's life and quite often the child's. Where the os is, or can be, rapidly dilated fully, deliver as quickly as possible—with or without forceps—and immediately thereafter insert the hand and remove the placenta.

To do a bipolar version it is desirable that the woman be anesthetized, but here again we cannot always do what is desirable. If we

can give hyoscine, morphine hypodermically and follow with a whiff of ether or chloroform, we should do so; the woman is always to be placed across the bed and the position of the fetus definitely learned. It is, as I have said, not a difficult matter to secure a foot if the breech presents or a transverse presentation exists. It is not, however, always easy to get a foot through the internal os with two fingers in the amniotic cavity, even with the other hand making pressure outside. In such a case pass a bullet forceps with the left hand into the uterine cavity and (using the fingers as a guide), grasp the extremity and pull it down. If you are wise you will loop a piece of gauze around the ankle; thus traction can be secured at any moment. If by error a hand is pulled through, tie a long strip of gauze to the wrist and push the arm back. Later you can prevent extension of the limb by traction upon the strip.

In city practice the use of the Ribes' bag has to a certain extent done away with the necessity for such procedures. It is not at all difficult to insert the bag through an os which will only admit a single finger. It is filled after insertion, and of course hemorrhage can be very positively controlled till normal labor occurs. In country practice, however, the bag is rarely at hand when wanted; moreover the country doctor generally gets to his cases of placenta previa to find immediate delivery imperatively necessary. He has then to choose whether he shall run the risk of dilating a soggy cervix, and do an internal version or a bipolar. In my own practice I have been able to dilate, insert my hand and bring down the extremity (one or both) in all but one instance, and then I did a Hick's bipolar, the woman being delivered two days later of a dead male child. I believe for the average man it is safer to tampon and wait, where there is too slight dilatation to permit the entrance of two fingers at least; if he can insert three it is not difficult to insinuate the thumb and secure a foot in breech cases.

To do a bipolar version successfully it is essential that the accoucheur be able to distinguish the fetal parts and it is advisable to study the feet, hands, knees and elbows of every new born child.

Only by practice can we become perfect.

THE PROPHYLAXIS OF TYPHOID FEVER.*

By A. F. WILLIER, M. D., Springfield, Mo.

The medical profession constitutes the chief safe-guard of the health and, indirectly, the welfare and prosperity of a nation. This fact is continually being demonstrated, especially at our large sea-port towns, when, at various intervals, serious outbreaks of a contagious and virulent disease or plague is threatened. Then it is that the unbounded activity of the local boards of health, ably assisted by the self-sacrificing efforts and often gratuitous services of the individual members of the medical profession, render a service to the country the value of which can never be over-estimated. The loss of lives prevented, the expenditure of large sums of money made unnecessary, the general paralysis of business averted, but above all, the ability of the medical profession to cope successfully against an evil, which could cause more devastation than war and famine combined, all is clearly demonstrated.

In striking contrast to the usual zeal and activity of the medical fraternity in the threatened appearance of some form of pestilence or plague, is their general apathy and seeming indifference to an invasion that annually carries off 350,000 people in the United States. While typhoid fever, with its great variety of changing symptoms, variable courses and serious complications, its different sequelæ and terminations, has, perhaps, first place in clinical interest for us, still it is to its prevention that we must devote the greatest attention. A disease now more of smaller communities than of the larger cities, its control offers many difficulties, still its stamping out is one of the greatest problems before the medical profession of this country. Its great sacrifice of human life and enormous percentage of morbidity in the United States alone is appalling, and yet we are not justified in styling it a non-preventable disease. In 1900, it is estimated, there were 350,000 cases of typhoid fever in this country, 35,000 of whom succumbed to the ravages of the affection; the death rate being 33 per 100,000 population, the mortality being 10 per cent. This is double the rate in England and about three times the rate in Germany. It is true the mortality is slowly decreasing, but we are justified in making this statement regarding any of the severe infectious or contagious diseases. Every patient with typhoid fever means infection from a previous case. If thorough disinfection had been carried out in every case of typhoid fever last year and the same this year, there would be a very large decrease in the number of cases for the following year.

*Read before the Greene County Medical Society, March 11th, 1910

A rational system of disinfection together with isolation constitute our most potent means of combating this, as any other infectious disease. A rational system of disinfection is based upon a definite knowledge of how the disease is spread and upon peculiarities of the infectious agent. Disinfection, in typhoid fever, if an attempt is made to comply with this precaution, is generally left in the hands of people, with vague instructions, who do not realize the importance of its being done thoroughly; accordingly it is done, if at all, often in a careless or shiftless manner. Too often does the medical attendant fail to realize his own responsibility in this respect; he is entirely contented if he brings the patient safely through the attack, heedless of the danger that may befall the community. This is a deplorable fact, nevertheless the statement remains true. The situation reminds me of the public's attitude in the presence of a large fire, they run to it, but always walk back. We are generally most zealous in piloting the patient through his weeks of illness, but only too often careless or indifferent in attempting to prevent any other or fresh infection. In fact we are entirely illogical in our attitude toward typhoid fever; we consider an ounce of cure worth many pounds of prevention. A city is exposed to infection year after year and little is done for the many, but for the individuals with the disease, hospitals, physicians, nurses and attendants work every hour in the twenty-four. How much better to remove the necessity, or strive at least to take preventive steps to guard against the infection. We in America, especially, should be interested in stamping out typhoid fever, since it has gained such a foot-hold here, Osler writes: "Of no other disease can we read as full a history from American sources alone." Reports of typhoid fever in a city may be taken as a safe indicator of its sanitary status. On the same principle it has been found that whatever tends to better the sanitary arrangements of a city, diminishes to a corresponding degree the prevalence of the disease, particularly improvements affecting the water supply and drainage.

The character of the water supply and the means of disposal of the excreta must be regarded as the most important factors which influence the occurrence of the disease in communities, while filth, bad hygienic conditions and crowding have a certain effect. But under any condition or climate, the essential factor which governs the occurrence of the disease is the manner of disposition of the excreta. The most important part of the typhoid fever problem is its prophylactic consideration. The etiology, pathology, symptomatology and diagnosis are well known; in the treatment we can do very little, but in the prophylaxis much remains to be done. We willingly give our time and attention to the patient with the disease, but generally fail to carry out sufficient preventive measures. We hold that infected water and milk are some of the principle causes of the disease, but we are prone to overlook the fact that these are but some of the results of a previous case that did not receive due attention. The typhoid fever bacilli do not naturally inhabit water and milk, although it is true they may exist in them for a while and even multiply, but the

natural abode of the bacilli is in man himself, the water and milk merely serving as carrier from host to host. If it were possible that every typhoid fever bacilli might be killed on leaving the host, the disease would be at an end. But there are many difficulties that stand in the way. Many cases of typhoid fever are of such a mild variety that a diagnosis hardly seems warranted, such cases being unrecognized sources of danger. Again the disease seems to have gained such a foot-hold in this country especially, that its stamping out would appear well-nigh hopeless, in fact it might seem useless to begin the struggle. Still every thorough measure of prophylaxis counts, and when it is considered how easy it might have been to prevent epidemics had the proper care been exercised with the first case, there is much to encourage the medical profession to be on guard with each and every following case of typhoid fever. Practitioners who absolutely disregard all prophylactic measures in treating their cases, merit the censure and reproof of the local societies; moreover, the local board of health should investigate such inability or ignorance and act accordingly. It can not be estimated how many cases of infection may be prevented by thorough disinfective measures with one patient, but it can often be estimated how many cases of infection arise from one patient whose excreta has not been properly disinfected. Especially does this apply in small communities. The history of a typhoid fever invasion is often like that of a large fire—a small beginning with increasing and disastrous extent. This is strikingly demonstrated in the case of a typhoid fever patient living in the vicinity which yields the water supply of a town. To disinfect properly his excreta involves very little work, but allow the water supply of the community to become contaminated from him, and thousands may become exposed to the infection, and prevention then may involve elements and circumstances practically impossible to control.

The prophylaxis of typhoid fever may be considered under two heads: (1) General sanitary measures for the protection of the community at large, and (2) special measures in connection with the patient. The general measures of sanitation properly belong to the domain of public hygiene or boards of health, but much can be attained by the private practitioner. The problem resolves itself into the supply of pure food and water. There is no country that is entirely free from the danger of a typhoid fever invasion, and the water supply is everywhere a most important element, as has been proven by the lessened mortality of cities from typhoid fever after a system furnishing pure water has been introduced. Typhoid fever is, in the majority of cases, a water borne disease, the water being infected directly by sewage and indirectly by saturation through the ground from out-houses; careful inspection, therefore, and regulation of the area from which the water supply is derived, and particular care of the water after it has been collected by means of filtration, should be sought. The importance of maintaining all public water supplies at the highest degree of purity and wholesomeness is well recognized.

Municipal ownership of water works, as being more conducive toward securing this standard, is hereby favored. Wells in country places should be situated far from any source of contamination; they should be deep and protected from surface water; even then they are a menace to the neighborhood. Wells in the city, I am of the opinion, should be heartily condemned, especially where other water can be procured. Sewer connections to all out-houses or closets should be compulsory in all places where a sewer system is established. The most likely food to convey infection is milk, introduced by infected water being used to cleanse milk-bottles, etc., or by being added to the milk for economic purposes. The milk supply of a city should be under the inspection and control of local sanitary authorities. Boiling will destroy all germs, but not so freezing; ice cream may thus carry the infection past most of the ordinary defenses. Vegetables washed in infected water, or fertilized with sewage, oysters and other food articles, serve also as conveyors of the disease. Good drainage is also an important factor in the prevention of typhoid fever in cities and towns. When the streets and alleys are kept free from garbage, manure or other impurities, the liability to typhoid fever is lessened since the bacilli grow much more rapidly in soil saturated with sewage. Air borne contagion is not a remote possibility, inasmuch as the germs may be diffused in the dust of dried excreta and light on exposed articles of food. Flies are also a carrier of the bacilli, especially in armies. It is apparent that as regards the danger from the above sources, the ordinary individual can do little to diminish it. He may see that his water and milk are boiled before using during an invasion of the fever, and may exercise even the greatest possible caution in the preparation of all his food, but to control absolutely the entrance of any typhoid fever bacilli into his system, he is powerless. How much more important and simpler, therefore, to control the dissemination of the bacilli at their source, as this and this alone strikes at the root of the evil. During an epidemic of typhoid fever every care should be taken to boil both water and milk before using and all possible sources of infection through either of these should be watched and guarded against; all uncooked food should be regarded as dangerous. I am of the opinion that typhoid fever should be handled, in connection with the medical attendant, by the local board of health, or at least under their control, as is done with scarlet fever, smallpox and diphtheria. There is a great cry of distress raised by the public, when the knowledge of an existing case of smallpox becomes known, yet an epidemic of typhoid fever seems hardly sufficient to warrant their attention. The medical fraternity, too, becomes slightly flurried when smallpox invades their neighborhood, while the annual invasion of typhoid fever is only of passing importance. Yet, in the State of New York, for example, where sanitary conditions are as good or perhaps better than in the majority of other states, in 1907 there were 1702 reported deaths from typhoid fever, while there were only 10 reported deaths from smallpox. It seems the public at large refuse to accept the danger and

seriousness of a typhoid fever affection. Compare the public attitude toward a patient with typhoid fever and toward one with smallpox or diphtheria, and we have the explanation of many of the difficulties. It is the old story of familiarity. I believe the local boards of health, acting in connection with a public or national board of health, were they properly empowered and, more effective still, properly paid, could greatly assist in lowering the mortality of typhoid fever. They could isolate the patient suffering from the disease, which is of primary importance; they could more properly and effectively enforce thorough disinfection, which is of the greatest importance. It can not be doubted that typhoid fever, under their regime, would rapidly decrease, for every patient properly handled one year would mean fewer cases to care for the following year.

Of more importance than the general measures, just referred to, would we attempt to stamp out the disease, are the special measures to be observed in connection with the patient suffering from the affection; for until the medical profession realizes its importance and, what is more, carries it into practice, the prevention of typhoid fever is more or less hopeless. In brief, these measures consist in the isolation of the patient and the disinfection of the excreta (stools, urine, vomitus and sputum). Complete isolation of the patient should be sought, special wards should be provided in hospitals, and in private homes special apartments should be reserved for the patient, and none but the attending physician and nurse should enter, since the attendant may carry the bacilli directly by handling food or drink, which in turn may be given to healthy members of the household. If extreme care is not exercised, the excreta may become dry and scatter about or be carried by flies to meat and milk and there multiply indefinitely. Dried bacilli may also be inhaled and swallowed. There is, too, incontestible proof that typhoid fever is slightly contagious. The sick room should be kept absolutely clean, well ventilated, free from all unnecessary furniture, screened to keep out flies, and have a sunny exposure if possible. The patient should be sponged regularly and all soiled clothing at once removed. He should, at all times receive careful attention, and after each movement of the bowels, the anal and sacral regions should be cleansed with a disinfectant solution, carbolic acid 1-40 or bichloride of mercury 1-1000. After micturition, or if any urine has been spilled, the same thing should be done. The physician and nurse should cleanse their hands with a mild antiseptic solution after attending the patient. But it is to the importance of a thorough disinfection of the urine, feces, sputum, vomitus and bed-linen that this paper is primarily directed, since the value of their disinfection is of paramount importance in considering the prophylactic or other treatment of typhoid fever, striking, as it does, at the root of the evil. This is by far the principal prophylactic measure of the typhoid fever problem. Although, being of the greatest importance, only too frequently does it receive the least attention. As already mentioned, too often does the medical attendant fail to realize his own responsibility in this respect; his entire aim and goal, laudable as

far as it goes, being to bring the patient safely through the attack, heedless to the general havoc that may be wrought to the community by his failure to make any effort to disinfect the excreta of his charge. During the epidemic of typhoid fever in our city last year, I am familiar with one case, a very virulent attack, from which as a failure to disinfect the excreta, they being carelessly thrown in an out-house, four other people contracted the disease as a result of drinking water obtained from a well on the same premises. Each individual case of typhoid fever should be regarded as a focus of infection and handled accordingly.

Stools. The proper disinfection of the stools is a difficult matter, as the bacilli may be contained in a mass of fecal matter which is penetrated with difficulty. It is always well to place a pint or more of the disinfectant solution in the bed-pan before it is used, adding a sufficient amount afterwards to completely cover the stools. The solution and feces should be thoroughly mixed, the solid masses being broken up with a glass stirring rod, the mixture then being allowed to stand for three hours before being consigned to the toilet or closet. All excretions should be received in a vessel that can be thoroughly disinfected inside and out. The feces may be disinfected in any of the standard solutions, as milk of lime, chloride of lime, bichloride of mercury or carbolic acid; the latter one being perhaps preferable since it is easily obtained and as easily made to the proper strength, and accordingly the chances for mistakes are few; it is used in the strength of 1-20. Disinfection of the stools should be carried out until the patient is convalescent.

Urine. The disinfection of the urine is often neglected even when the stools receive the proper attention. Because of the frequency with which it is voided, its comparative inoffensiveness, its easy dissemination and the relatively great number of organisms present, infected urine may be even the most dangerous excreta of the typhoid fever patient. Nurses and attendants should be taught that the urine may contain typhoid bacilli at any time, and is a constant source of danger to themselves and others. Urotropin internally has a good effect in destroying the bacilli in the urine. Carbolic acid and bichloride of mercury are the more common solutions used for the disinfection of the urine; they are used in the same strength as for the disinfection of the feces. The urine may be poured in a vessel in which the disinfectant solution has been placed, the latter always being in excess, and the mixture allowed to stand for two hours before being thrown out. The urinal should be kept in a disinfectant solution when not in use. The urine should be disinfected until the patient is convalescent, and no patient should be discharged from observation while the bacilli still remain in the urine.

Sputum and Vomitus. Handkerchiefs and cloths which are used for receiving sputum and vomitus, should be placed, for at least one hour, in boiling water, before being sent to the laundry. But for catching the sputum and vomitus, and for cleansing the mouth and nose, it is best to use gauze cotton rags that can be burned after using.

Clothing. When removing linen, whether at the daily change or from soiling, it is always best and safest to disinfect with a carbolic acid solution 1-40 as a matter of routine, as at times it is difficult to say whether they may have been contaminated or not.

Individuals who have had typhoid fever should be instructed as to the danger of disseminating the disease by their lack of personal cleanliness, they should be instructed to wash their hands carefully after urinating and defecation. In fact, habits of general cleanliness, by all people at all times, should be encouraged. The dangerous character of public objects, from which there is a possibility of infection, as from door-knobs, telephones, hand-rails, public seats in the theater, cars or park, should be brought to the public mind; warning as to the cleanliness of the hands and fingers before eating after handling these objects, advising against the habit of putting objects, as money, in the mouth, and the danger of infection from public drinking cups, should be made known. All those who are attending a typhoid fever patient should be careful to disinfect thoroughly their hands after caring for the patient. Before eating, the attendant should be certain that his hands and fingers are not contaminated with any of the discharges. It is always advisable to use hot water and soap, followed by a bichloride of mercury solution 1-1000. If possible, the one in charge of the patient, should have nothing to do in the preparation of the food for the rest of the family; in fact he should remain away from the kitchen entirely if circumstances will permit. In cities, where a proper system of sewerage is maintained, some difficulty is usually experienced in having all excreta thoroughly disinfected, since the general public feel that the germs are to be carried where there is no chance of their doing harm. We can not be sure of this in any case; oysters may be fattening close to the outlet of a sewer, water-cress may be growing along the sides of a near-by or connecting stream or its innocent looking water may be used in washing vegetables or in cleansing cooking or eating vessels; moreover, it is our duty as physicians to destroy every bacilli, no matter where it otherwise might go.

Within the last few years, attempts have been made to shorten the course of typhoid fever by subcutaneous injections of a sterilized liquid made from the cultures of typhoid fever bacilli. It is yet too early to predict to what extent vaccination against typhoid fever may be used in the future. Encouraging results have already been obtained, but further experimentation is necessary to establish its immunizing and curative effect.

Typhoid fever is disseminated by the transference of the excretions of an infected individual to the alimentary canal of others; prophylaxis is thus best obtained by killing the bacilli when they leave the patient. Measures to prevent their introduction into healthy individuals are necessary and indispensable, but it is like the attempt to kill millions of mosquitoes which might never have been had the eggs been destroyed. It must be confessed that the task of attempting to stamp out typhoid fever

is no small one, for it involves much labor and conscientious care, more than the majority could or would give; still, as mentioned above, were the proper power given to competent authorities, such as health boards or departments of public health, a most valuable aid in securing a higher standard of prophylaxis for this and other virulent diseases would be established. Too the individual American physician of to-day could greatly assist in the attempt to control the disease, by each giving more attention to this matter of isolation and disinfection especially. With these two allies, it is certain that the disease, which inflicts such enormous injury upon the people of the United States, imposing such vast and needless human misery and pain with its weeks of suffering, and sustaining such great loss for us financially, and in prestige and power, would grow less, from year to year, both in the number of victims and in the percentage of deaths.

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THE REGULAR PROFESSION AND THE ISMS.*

By H. J. ROWE, M. D., Willard Springs, Mo.

By the regular school of medicine is meant the school of medical practice and teaching which is based upon principles accepted by the great body of physicians, and founded upon the experience and scientific investigation without strict adherence to any theory of therapeutics.

To the regular school of medicine humanity is indebted for all the distinct advances in all medical and surgical science. The discovery of vaccination, by Jenner, has saved thousands of lives and untold suffering. The discovery of the germ of the disease has led to great advance in the prevention and cure of many diseases, and has given us serotherapy, which has robbed the dread disease diphtheria of its terrors, as well as tetanus and many other fatal maladies.

Who to-day are taking the lead in hygiene and preventive measures? Who are the investigators who are trying to stop the spread and find a cure for the great white plague? Who has placed the science of ophthalmology where it is to-day whereby thousands of bright children are saved annually from ignorance and blindness?

Do these advances come through the efforts of the Christian Scientists, the osteopath and like isms? No, they all come from the regular profession, they taking the broader view, investigating and accepting all that is good without strict adherence to any one theory of therapeutics.

The regular physicians are not hydropaths; yet they believe that wa-

*Read before the Howell County Medical Society, December, 1908

ter has its therapeutic use in the treatment of disease. They know that electricity is a valuable aid in the diagnosis and treatment of disease, but do not exploit it as a cure-all.

No one knows better than the regular physician the intimate relation of body and mind, and the value in many cases of suggestive therapeutics, but he does not try to cure all diseases by this method, as does the Weltmerite. The regular physician appreciates the value of massage and Swedish movements, but does not consider it alone a system of therapeutics for the treatment of *all* diseases. On the other hand the isms take up some particular fad, and exploit it as a cure for all the ills the flesh is heir to. They spring up suddenly and make wonderful and ridiculous claims for their particular ism. They ignore all the scientific investigation, past and present, and no difference how absurd their theory and ridiculous their claims, they find many converts, and among them many of the more intelligent class.

I know of several people of ordinary intelligence, who sent Weltmer \$5.00 for absent treatment, and claimed to have been benefitted too, and had not the government issued a fraud order against him, he would, by this time, have been several times a millionaire.

Look at the claims of the late Alexander Dowie. He said he was Elijah the Second and an apostle of Christ, and was able to cure all disease by the laying on of hands, and he had a big following, not all of them illiterate and ignorant, but many were educated and considered highly intelligent.

Look at our Missouri ism; the osteopathic school of Kirksville. Absolutely nothing in it except massage and Swedish movement. Dr. A. T. Still, the founder, claimed to have discovered that the cause of all disease was misplaced bone, and gave the ism the name of osteopathy, and ignoring all scientific investigation and knowledge based on the experience of the brightest minds of the world of all ages, discrediting the achievements of Jenner, Virchow, Pasteur, Von Behring and thousands of other conscientious investigators, claims that *he* has discovered the whole cause of *all* diseases in the misplacement of bone, and to effect a cure, all that is necessary is *scientific manipulation*, as taught by *himself*.

Could anything be more ridiculous? Yet, look at the thousands of converts to osteopathy. See how the different state legislatures have thrown a protecting arm around them, licensing them to treat all manner of diseases, from belly-ache to diphtheria, by the science of osteopathy, and also to practice obstetrics. I noticed a decision of some court in New York recently, that osteopaths were not allowed to use any kind of instruments, which I suppose would prohibit them from using Obstetrical forceps, and I believe if it was fairly tested in the court, they would not be allowed to practice obstetrics, for I don't see how any sane person could attribute the puerperal state to misplaced bone. However,

there is as much reason for so doing as to attribute smallpox and pneumonia to a like cause.

Why is it that the different isms, with nothing to recommend them but their own claims of miraculous cures, continue to flourish, and make converts of people who on other subjects are well informed and intelligent? What should be the attitude of the regular profession toward these isms, and what methods should be pursued to save the people from their own folly?

To the first question I would say, that many things contribute to the popularity of these isms, one of which is a superstition handed down from the Dark Ages, that cures of human ills must be something mysterious and miraculous.

We all have patients who like to tell how some doctor, at some time, came to them just in the nick of time, and by some method or wonderful remedy (which they would lead us to believe, was known only to himself), jerked them from the very jaws of death, when they were almost in sight of the pearly gates (or that other sea-port).

Another contributing factor is the ignorance of the laity as to what rational medical science really is, and what the regular profession has done and is doing to-day for the prevention and cure of disease.

The regular physician, as a rule, is ethical. He does not advertise in the lay press and tell what he can do and the wonderful cures he has made. This is as it should be, and we would not have it otherwise; but there should be some means of teaching the masses that different diseases are the result of certain fixed causes, and that cures are affected by rational, intelligible methods.

The reader takes up his paper and sees the card of the regular physician, that his office is in a certain place and certain hours are office hours. He turns to the next page and reads a whole column of how Dr. So and So, of world-wide fame, has discovered a sure cure for cancer, consumption and several other things, said cure known only to himself, thus stimulating that belief in the mysterious, and making him a ready convert to the first new ism that comes along. He takes up his monthly magazine and learns something about nearly all the sciences, and reads many articles on Christian Science and kindred isms, but sees few articles on the rational scientific medicine and hygiene by competent medical authority.

As to the attitude of the profession towards these isms, and the best method of educating the public to a correct idea of the cause of disease and the rational methods of cure, there are many different opinions. Some will say, "Do nothing." Ignore them, their theory is false, and the people will find out by and by, and they will play out. True, the time is coming, but so is the millennium, and while we are saying nothing and doing the ignoring act, the isms are active and sending literature to every one who will read it, presenting their isms in the most plausible way, and it

appears plausible to those who know nothing of anatomy and the cause of disease.

There is one thing peculiar about the converts to these isms. Each one seems to appoint himself or herself a committee of one to act as advertising agent for the new ism, and they will talk it all the time. They go to see all the sick and gently suggest that they try Christian Science or osteopathy or whatever it may be. If Dr. Isms has a patient, they all visit this patient and encourage him by telling him of the wonderful cure Dr. Ism has performed. However, I believe some of them are like the small boy who plunges into the swimming hole the first day of April, and says, "Come on boys, the water's fine."

I believe it is the duty of every regular physician to ignore these people as doctors, and explain to their friends, who may be impressed with them, the absurdity of their claims. When the doctor is asked if he does not think this or that ism might help his chronic malady, the doctor should tell him, in no uncertain language, just what he does think of it. I say this in face of the fact, that I have, probably, lost more practice by pursuing this policy than by all other causes combined.

I remember about eight years ago I was called upon to assist one Doctor Ism with a difficult case of obstetrics, and refused to go into consultation with him, and have had about one-half of the church to which this patient belonged, fighting me ever since; but, notwithstanding the fact that we will make enemies, at times, by pursuing this policy, I believe it is a duty we owe the profession and the public. If you accord them a semblance of recognition you cannot tell how far-reaching may be the result.

Let us suppose that Dr. A. has a case of chronic rheumatism that he has treated for a long time, and this patient reports that he is no better, and that his friends want him to try the osteopath, and wants to know what Dr. A. thinks about it. And, supposing, Dr. A. has treated this patient until he feels that he would like a rest, as we all sometimes feel with these chronic cases, or the friends who want him to try osteopathy are influential, and the Doctor does not like to antagonize them, and he temporizes and says, "Well, I don't have much faith in osteopathy. It may be all right for rheumatism. It *might* do some good." Has Dr. A. been honest with himself and patient and true to his profession? I think not. He knows that rheumatism is not due to misplaced bone, and if he thinks that massage is indicated, he should have given it or had the nurse do so, and this *might do some good* will be construed as a complete endorsement of osteopathy, and this patient will tell that Dr. A. advised him to go to the osteopath, and his osteopathic friends will say that Dr. A. *sends all* of his cases of chronic rheumatism to the osteopath. Then after six months have passed, and the weather has gotten warm, this patient gets better. This is then heralded as another great cure where *all* the medical doctors had given the case up as hopeless. This patient believing something has been done for him, becomes a great believer in the isms;

and when his child takes membranous croup, he sends for the osteopath, who rubs it until it is too late for anything to be done for it.

Is not the doctor, who said osteopathy *might* help rheumatism, to blame for this child not receiving proper medical care? I think he is. This patient knew nothing of the cause of disease, and he read in the pamphlets furnished him, that this ism cured all manner of disease, and is less to blame than the doctor who failed to stamp it as a fraud.

As to the best methods to be pursued to place the regular profession and the isms in their proper light before the public, I would say, in the first place, every physician should take an active part in politics and strive to have laws enacted which will require the same proficiency for all who treat the sick.

The young man who wishes to become an M. D., must have an education equal to a four year high school course. He must attend a good medical school for four years, and after receiving a diploma, must go before the State Board of Health, stand an examination and get a certificate, and register this certificate with the county clerk before he is allowed to treat the sick.

The young man who wishes to practice osteopathy, is not required to have a certain standard of literary education. He goes to Kirksville for a few months. Does not have to go before the State Board, and is not required to register in the county where he practices; yet treats the same class of disease as the M. D.

Why the discrimination against the regular profession? What does it mean? It simply means that doctors have not been active enough in politics. They have been doing the "ignoring act."

A few years ago there was a medical practice act introduced in the Missouri Legislature, which required an equal proficiency for all who treat the sick. What did the regular profession do when that act came up for passage? *Nothing*. What did the isms do? They poured into Jefferson City by the trainload, and the osteopaths succeeded in being exempt from the provisions of that act, thus, legalizing osteopathy in this state. Had the regular profession taken the same interest in the passage of that bill as the isms did to defeat it, that exemption would not now disgrace the law-books of the state of Missouri.

The people should be educated as to the cause of disease and its prevention, for only by this means will we be able to procure proper medical laws and suppression of quack isms, and there is no one so well fitted to push this campaign of education as the ethical regular physician. I think we should have more open sessions of our county societies to which the public are invited, with specially prepared programs of interest to the laity. I think each county society should appoint a committee on public health and hygiene. One of the duties of this committee should be to write timely articles, taking such subjects as typhoid fever, giving cause, the danger of impure water and milk supply, etc., submitting these

papers to the county society for their approval and then have them printed in the county papers.

There should be a like committee from each state society, papers handled in like manner and printed in leading magazines, such as *The Scientific American*, *Ladies' Home Journal* and other widely read periodicals.

THE GYNECOLOGIST OF TO-DAY.*

By WALTER B. DORSETT, M. D., St. Louis.

So great has been the advancement of medicine along various lines that specialties have become more or less blended and it is with difficulty that we can select a practitioner who follows what was formerly considered a special line of work.

The writer knows practitioners who until recently, for example, confined their work to diseases of the eye; now they have included the ear, nose and throat, and many who call themselves oculists treat diseases of the ear as well.

Until within the last ten or fifteen years the work of the gynecologist was limited to such therapeutic measures as may have been administered through the vaginal speculum. To-day, he who limits his work to the narrow confines of his office cannot be considered a gynecologist.

It is not my purpose nor intention to underestimate the importance of the treatment of a certain class of cases that do not require major surgical operations; I still believe the Hodge and Albert Smith pessary, the depletion and counter-irritation, as well as the application of other therapeutic measures, have their places in gynecology; and I believe he who is inclined to underestimate these important matters is not competent to judge as to who is, or is not, a gynecologist. So important are they that to ignore them is to lose sight of means whereby women are saved from many unnecessary mutilations incident to operations. I am aware that just criticisms may be cast upon methods of the routinist who indiscriminately applies remedies in his office treatment, in an empirical way and often without rhyme or reason. The fault, however, should hardly be laid entirely at his door, for the reason that the teaching of the subject in our medical colleges is shamefully neglected; for the teacher usually is himself enamored with the purely surgical side of the subject and neglects the important non-operative side. True, the outdoor clinics at the college buildings are of benefit in enabling a limited number of students

*Address of the Chairman of Obstetrical Section, St. Louis Medical Society, January, 1910.

to inspect pathological conditions macroscopically, but they are not enabled to follow these cases to their termination as well as they are to follow cases that have been operated upon, so that their usefulness is materially limited.

The difficulty of maintaining a well attended gynecological clinic is well known to those of us who have attempted it. There are few women of the great number who are in need of gynecological treatment willing to subject themselves to the inspection of a class of medical students. This is shown by the large number of patients who avail themselves of clinical treatment during the summer months, between college terms, as compared with the comparatively small number who attend during the school session. So that it is clearly shown that such stimuli as are sadly needed in the teaching of non-operative gynecology, do not exist.

In the consideration of the subject of this paper we are forced to admit that the gynecologist's territory must extend somewhat into the field of general surgery. The possibilities of the invasion into the hitherto forbidden fields have become so great in these days of modern medicine that the gynecologist must necessarily be well grounded in abdominal surgery, not alone as it may bear upon the uterus and adnexa, but the appendix, the intestines, the spleen, the gall-bladder and the kidney. In suppurative diseases of the adnexa, complicated with pathologic conditions of the appendix and intestines, in fibro-myxomatous disease of the uterus, in tumors of the ovaries associated with adhesions to the bowel more or less dense; in obscure intra-abdominal diseases of any nature in which exact preoperative differential diagnosis is impossible, the gynecologist is expected to be and should be, equal to the task that is often necessarily presented.

Some time ago I asked a gynecologist if he confined his work to diseases of the uterus and adnexa, and he replied in the affirmative. I then asked him if he ever removed the appendix when it showed pathological lesions during the progress of an operation on the uterine adnexa, and he again replied in the affirmative. The answer to the last question of course negated the first. Is it not, therefore, reasonable to assume that such a specialist is not as well equipped to deal with intra-abdominal diseases as the abdominal surgeon? To reply affirmatively to this certainly weakens the defense of the specialist as to his right to the title of gynecologist.

Specialization should be well grounded upon pathological as well as anatomical grounds, and what we find to do should be done, and he who does the most work along certain lines is best prepared.

Obstetrics as a specialty has been by custom linked with gynecology and as obstetrics may be considered the maternal ancestor of gynecology, and most of us now who claim the title of gynecologist have served a certain pupilage in obstetrics, we naturally should reason that these specialties should go together. Theoretically these are good grounds for reasoning, but practically we know that they conflict so materially that the one has to be abandoned for the better pursuit of the other.

When gynecology has been chosen as the one to follow we naturally invade the field of the general surgeon and do intra-abdominal work. The perusal of the lately written text-books on gynecology will convince us that most of the recent writers include in their writings well written chapters on nephropexy, appendectomy and splenectomy. Among these may be mentioned Palmer Findley, who contributes one chapter each on diagnosis of diseases of the ureters and diagnosis of diseases of the kidney; C. Hubert Robert, an English author, one chapter on diseases of the ureters including calculus; Barton Cook Hirst, one chapter on diseases of the urinary tract, which includes floating kidney with specific directions in the operation of nephropexy; Tod Gilliam, chapters on diseases of the ureters, kidneys and rectum; Reed, one chapter on the rectum. Howard Kelly, one chapter on diseases of the ureters, one chapter on the detection of calculi by means of the x -ray. |

It is, then, shown that the natural trend of modern gynecology is toward abdominal surgery. In the consideration of this subject we should not lose sight of the tendency of the embryo gynecologist, who, after having been graduated, immediately begins his exploits into the field of abdominal and pelvic surgery without having served an apprenticeship with a competent master. The tendency in this direction is so great that we cannot refrain from uttering a cry of warning. In this our country of free thought, free speech and I may add free action, the mutilation of our women will soon bring disrepute upon our specialty. Many who would not dare to remove an adenoid or enucleate an eye, do not hesitate in the attempt to do hysterectomies or remove pus tubes. So patent is this question that it may require legislative enactment to put a stop to it.

APPENDICITIS, DIAGNOSIS AND TREATMENT.*

By G. A. DELAMATAR, M. D., Rich Hill, Mo.

The diagnosis of appendicitis in certain forms is, I believe, rather an easy matter, while in old cases, and especially in complicated ones, most difficult, if not the most difficult of all the abdominal cases the surgeon has to deal with.

Inasmuch as there has been so much written, and so much discussion, as well as so much lack of positive knowledge, as to the exact condition present in the different varieties of appendicitis, and especially in the different stages of the disease, it would be impossible for me in one paper or reading to fully cover the entire subject. I will therefore treat

*Read at the meeting of the Bates County Medical Society, September 30, 1909.

only upon the one variety, that of acute suppurative appendicitis. This is the variety that we as country doctors have to deal with most frequently and the one that requires immediate attention.

Diagnosis. There are two prominent symptoms common to all forms of appendicitis, viz: pain and vomiting; but there is a great variation in the character of these cardinal symptoms as well as the other symptoms associated with them, according to the lesion in or around the appendix.

When we are called to an acute case of suppurative appendicitis, the attack begins suddenly with pain in the epigastric or umbilical region, nausea and vomiting usually about the same time. There may be chilly sensations or not, but rarely a distinct rigor. Temperature may be normal or slightly elevated, and we will find always the pulse rate increased to around the 100 mark. After an attack of vomiting the pulse may reach 120 during the first of the attack.

After twenty-four hours the pain will be located in the region of McBurney's point. There may be slight tumefaction or not, but there will be rigidity of the right rectus muscles. This I consider a cardinal point. The pulse by this time is still increased, the tongue coated white and dry. The patient assumes an anxious expression, and upon deep pressure the pain is greatly increased. Localized tympanitis with distinct muscular resistance upon the affected side.

Should these symptoms subside at this point the inflammatory process will likely clear up rapidly, with one exception, that of tenderness directly over the appendix. This last symptom would confirm our diagnosis.

Should the case go on to suppuration, an abscess forms and the tumor will continue to grow from day to day until relief from breaking, or being opened and drained, and all of the above symptoms are aggravated, with new symptoms of septic intoxication appearing.

Examination per rectum may show the tumor to be plainly felt, and in the female per vaginum the tumor may be so closely in conjunction with the right ovary that we may be easily misled without a careful history.

As to the blood count. I am not thoroughly familiar. Greenough concludes that a leucocytosis is a fairly constant symptom; that a count of 20,000 on the first or second day, suggests a general peritonitis, but I can not remember in my experience, being able to discover a general peritonitis as early as this. That a count of 10,000 or less after the sixth or seventh day, a grave general peritonitis. But a count of 20,000 after the first week, a local abscess.

The cardinal symptoms are: Acute pain in the right lower abdomen; localized tenderness with or without tumor; rise in temperature even slight; nausea and vomiting, with right rectus rigidity, and the diagnosis is quite complete.

After the abscess begins to form, marked rigors and profuse sweating.

Differential diagnosis. The most common differential diagnoses are:

Renal colic: But there is usually no rise in temperature, and a history of renal disturbances.

Acute cholecystitis: An inflamed and distended gall bladder is rather above the umbilical region, no fever, and jaundice is often present.

Acute intestinal obstruction: There will be vomiting of fecal matter with early distention of the entire abdomen.

Salpingitis: There will be an exudate that will be rather lower down in the pelvis and one can nearly always trace the exudate later to the fixed uterus. I believe we will rarely get nausea and vomiting early in this case, and there will likely be a history of menstrual irregularities.

Appendicular colic: You will have no elevation in temperature.

Treatment. I still believe there are two stages when operating should be done, notwithstanding some of our eminent surgeons advise—always operate as soon as you are satisfied you have an acute attack of suppurative appendicitis, as well as at any time during the attack.

I believe during the first twenty-four or even forty-eight hours of an acute attack of suppurative appendicitis, that an operation carefully done under strict aseptic precaution is comparatively without danger, but after two, three or more days in which nature is trying to protect the adjacent parts, with perhaps a large amount of exudate, without a suitable limiting wall that is very easily broken, and that by the most careful operator, that it is better to wait, depending of course on the totality of the symptoms, until you are quite sure that you can open and drain without infecting the general peritoneum.

I well remember a case, not very long ago, of a female in middle age, who was sent to my place suffering with a protracted case of suppurative peritonitis of three weeks' standing. She was in a cold clammy perspiration, rapid feeble pulse, with marked distention of the abdomen and a large circumscribed tumor in right lower abdomen. Upon examination I was almost sure I could open and drain what seemed to be a large abscess without much difficulty, except from the exhausted condition of the patient, in which I was somewhat fearful of surgical shock. Upon opening the abdomen I found to my surprise the abscess was well walled off, but not attached to the abdominal wall. There was a considerable discharge of a brownish thin fluid which was washed and wiped out, and a drain of gauze established. I am quite sure had I attempted an opening of the abscess wall I would have very likely had an infection of the peritoneal cavity. A high enema brought away the appendix entire, and the patient recovered finally. The operation did not seem to cause any trouble whatever. Bold surgery in my opinion would likely have proved fatal in this case, and the operation have done no practical good. It was simply a case in which nature threw out a wall around the diseased appendix and it sloughed off into the gut.

This was an attack of acute suppurative appendicitis that should have been operated on early, and would have saved the patient weeks of suffering.

You will notice I took up the operating part of the treatment first. I believe it is the first thing to consider in an acute suppurative variety of appendicitis.

Of course I realize that it is almost impossible to get consent to operate early; nevertheless the number of practitioners who regard suppurative appendicitis as a medical disease is fast diminishing, and even those who claim that some attacks yield to medical measures are entirely unable to select, in the early stages of the disease, the case which they have confidence in treating by internal medication. No medical treatment has ever proven to be satisfactory in suppurative cases, and the pathology of the disease is such that there will likely never be.

I will state, however, that when I am called to treat an acute inflammatory attack of appendicitis, I would stop or limit all food, or at least restrict the diet to liquid and that to the limit depending on the general condition. I would not use strychnine as some of the profession would recommend, until absolutely necessary. On the other hand, I would use such mild sedatives as aconite, gelsemium, and if necessity veratrum in minute doses to modify the heart action, for I fully believe strychnine is greatly abused by the medical profession in many of our acute inflammatory affections. My reason for this is simply that when there is circulatory obstruction and the heart is laboring to re-establish same, before resolution can possibly take place, that it is far better to give the heart as much rest as possible until the time when it is, as I said before, absolutely necessary.

I have never used the ice pack, and can not speak of its value for I know it is not well tolerated long by the patient. I am a firm advocate of the use of turpentine applied to the abdomen when there is much distention, and I know it has served me well in many cases.

I am not an advocate of a milk diet, but prefer beef broth, malted milk well diluted and have allowed ice cream with benefit.

Absolute rest should be advised in the recumbent position, but counter-irritation is of no value, and may be of harm to the skin should an operation be performed.

Anodynes should be used if the pain be severe. The bowels should be thoroughly washed out, if they have not already freely moved as is very often the case, and I never use purgatives.

I have found heroin in 1/12 to 1/6 gr. doses to have worked very satisfactorily in allaying the pain and does not nauseate as badly as does morphine, codeine may be used as well.

Where there is much distention, I am sure washing out the colon using the high enema, is of great value in helping to eliminate the gas.

I always allow water as long as it does not cause nausea or vomiting.

I will not discuss the operative methods, as you are all familiar with the text in the ordinary removal of the appendix, but in the later stages of the disease, there are no two cases just alike, and the surgeon who is best able to judge what to do and just what not to do, after getting within the abdomen, together with absolute cleanliness, will have the best results.

Just a word regarding a suitable place for operating. I believe with good light and in the patient's home if possible, done under thorough sepsis together with careful nursing, is better than rushing a patient off to a hospital, notwithstanding that our city surgeons—most of them, not all—advise sending them to the city or to their hospitals and that for more than one reason, in their minds. We, as a rule, in country practice, only get the consent to operate after the case has reached the abscess stage, and at this time it is a matter of open and drain, or open, explore, dissect, and take chances. Surely if there is a chance for infection during an operation it is in a hospital where you have it all around, operating room, attendants, wards, private rooms and all.

LOBAR PNEUMONIA.

By W. S. LOVE, M. D., Bertrand, Mo.

Lobar pneumonia is an acute specific infectious disease produced by the diplococcus of Fränkel, characterized by inflammation, fibrinous and cellular deposits, and producing marked constitutional symptoms.

It attacks chiefly young, robust males and females, though no age is exempt. It is especially prevalent in temperate climates, and among those whose surroundings are insanitary.

While the primary cause is the diplococcus, there are many secondary causes for the advent of the disease, viz; exposure to sudden cold, getting wet, or in convalescing from such diseases as typhoid, measles, etc.

We divide the pathology of this disease into three stages, viz: first, or stage of congestion; second, or stage of solidification; third, or stage of beginning resolution.

In the first, or congestive stage, we find the entire capillary system of the lung, usually the lower right lobe, in a state of red, congested hyperemia, this condition lasting maybe an hour or a day; it then passes into the second stage, that of solidification.

This stage we may rightly divide into two parts, the first of which we call red hepatization in which we find a fibrinous exudate filling

the affected lobe, making it a solid lung, mottled externally and the pleura inflamed; it is heavy, and when cut we find this exudate to be made up of pure blood fibrin, red and white blood corpuscles and debris.

The second part of this stage, which we call gray hepatization, is really but the advance guard of beginning resolution. In it we find this solid red exudate beginning to soften and break down, the red lung begins to turn gray as a result of the undergoing decomposition of the fibrin, corpuscles, etc.

The third stage, that of beginning resolution, is that in which we find the exudate being absorbed and thrown off, followed by an amelioration of all symptoms and the convalescence of the patient. Or, if the case is not to terminate favorably, an abscess may develop through the plugging of some bronchiole; or gangrene may supervene from the closing of a terminal vessel; or we may get a fibroid or chronic pneumonia with a contraction of the air vesicles and small bronchi, and an overgrowth of interstitial tissue, a condition in which the tubercle bacillus is prone to manifest itself and produce a fibroid phthisis.

The symptoms of this disease are sharply defined. Its incubative stage is about two to five days. It begins with a distinct chill or chilly sensation usually prolonged, and usually at night. This chill, we are taught, is caused by the toxins produced by the propagation of the germ, and in children it often causes convulsions. Associated with the chill there will be a rise of temperature to 103° or 105° in a few hours, and it will hold its maximum for a few days, or until the absorption of the exudate begins, when it will suddenly fall, going out with a deep sweat, urination, or purgation, usually about the seventh or ninth day of the disease.

Pain is another symptom accompanying the chill; at first maybe a deep ache, then changing to a sharp stab; the deep ache being the sick lung, while the sharp stab comes from the inflamed pleura, usually located about the nipple on the affected side. Sometimes we find the pain elsewhere, showing it to be reflected.

Immediately following the chill we find painful respiration and shortness of breath; the patient cuts short the inspiration due to the severe pain, at the same time the number of respirations jump to 30, 40 or 50, and become grunting in type. The cheek of the affected side is flushed, the alæ of the nose playing in the effort at respiration.

Synonymous with these symptoms we find a change in the pulse. During the chill it is rapid and weak, but when the chill subsides it becomes slow, full and bounding, beating about 110 to 120. It is changed in proportion to the respiration, a sign which is pathognomonic of this disease. Instead of being 4:1, it becomes 2:1, or even less.

A cough comes with the chill, at first a short, ineffectual hack, very painful; as the disease progresses this cough becomes louder and more painful, at times being paroxysmal.

The sputa of this disease is typical and diagnostic. With the onset

of the second stage, it becomes the familiar brick dust sputum, or in some cases we find the "prune juice" variety, a thin, dark sputum. As the case continues this changes to a thick yellowish sputum which continues through resolution.

Nervous symptoms may be prominent in the course of the disease or not; there may be delirium of a severe type, or excessive headache. Alcoholic patients often become maniacal; children usually show severe nervous manifestations, especially convulsions.

We find the urine scanty, high-colored, full of urates and phosphates and may contain albumin. It never contains chlorides.

The physical signs of pneumonia are a very valuable aid to the diagnostician; inspection shows us the patient lying on his affected side with his knees drawn up, and the cheek of that side flushed, the alæ of the nose playing, the vessels of the neck and temples pulsing violently; also we see the broad, white-coated tongue, and possibly fever blisters on the lips. By palpation we find over the affected lung markedly increased fremitus, especially in the second stage; the skin is hot, the heart throb full and deep; resonance is usually impaired, though we may get Scott's resonance, or an increased resonance instead. In the second stage percussion over the affected lung gives dullness, this dullness gradually decreasing in the third stage to a normal vesicular note. If we percuss over solid lung with the patient's mouth open, we get a metallic ring. Auscultation is most valuable; in the first stage on deep inspiration we get a crepitant rale, some diagnosticians claim this to be due to an associate pleurisy, others to a stuck vessel; in the second stage we get no rales at all, because the lobe is solid; but we get tubular breathing. The voice sounds are greatly increased through the solid lung; in the third stage we get the rale redux, or the return of the crepitant rale of the first stage, also submucous and mucous rales.

The prognosis of this disease varies with the conditions attendant. In young, robust adults, with a moderate involvement and without complications, we have a right to expect a favorable outcome; in the case of patients who are very old, or enfeebled from other causes, we should be very careful in giving our prognosis, for it is almost always fatal; in habitual alcoholics we should always give an unfavorable prognosis, for statistics have proven that about 98 per cent. of these cases die.

In the treatment of this disease there are two things that demand our watchfulness above all others, viz: the toxæmia of the second stage, and the danger of heart failure in the third stage. And, as no two cases run exactly alike, we must treat each case on its own merits symptomatically. The sick-room should have proper ventilation, without drafts; and the least material and human adornment we can get in the room, outside of a nurse, the better for our patient.

As to the medical treatment, personally I begin with a good purgative of calomel, following with a saline to sweep out the bowels; I apply a cotton jacket to the chest; and if pain is severe, I apply a hot poultice

to the affected area; I also give some form of opium with quinine in small doses throughout the first stage. If the temperature is causing too much trouble I give aconite and veratrum, also sponging with warm water or alcohol. I like my patients to drink plenty of water and have sufficient nourishment of liquids and semi-solids. For the cough, if it be tight, painful, and ineffectual, I prescribe some of the ammonia salts. About the fifth or sixth day, if the toxæmia is getting the best of my patient, I sponge freely with hot saline solution, or cool compresses. From about the sixth day, I begin to support the heart with small doses of strychnia or some good stimulant, and if resolution is slow, I put them on the iodide of potash, following this with a tonic of iron, quinine and strychnia.

OUR COUNTY SOCIETY.

By G. W. HAWKINS, M. D., Salisbury, Mo.

We are gathered at this annual meeting in commemoration of the birth of the Chariton County Medical Society. We who, some one has said, form a band of men who are occasionally overworked and abused, ill paid, much respected, greatly depended upon, and who are indispensable and honored citizens of every community:

We assemble as representatives of one of the greatest professions that work among men, trying to prolong the life of the sick and the cripple, and in the relief, the cure and the prevention of disease. To look back only a quarter of a century and see what our great profession has accomplished, it seems as bright and glorious as a noon-day sun that imparts light and heat to this mother earth of ours. Some of you have labored in this field until the bright rays of that glowing sun are growing dim in the western horizon. The frosts of many long winters are shown in your countenances, depicted more plainly than it should in some cases because of the irregular and professional life that we are honoring to-day; a life which from its irregularity leads some in the ways of ruin—dissipation. Insurance companies give our profession the lowest life schedule of all the professions. Self is often sacrificed in doing what we call a duty and pleasure to help the afflicted. But often as has been said, "Fools rush in where angels dare not tread." No nobler life belongs to any than that of the medical hero.

He is often on dangerous ground, so often has he risked his life that others might live. And where we read in the book of books, "Greater love hath no man than this that he lay down his life for his friends," it must have meant a physician, for here it seems to me that we have

heroes. I ask you to recall the recent coal mine disaster in Illinois. Who was the hero to lead the way to the entombed? The camp physician. "Who but Dr. Jesse W. Lazear, bared his arm and deliberately allowed an infected mosquito to inject the poison of yellow fever into his circulation and died that others might live? History does not recall a more Christ-like sacrifice than this, and time cannot eclipse it. He has lighted a torch for the guidance of men which can never be extinguished. No poem of praise can ever be sung to make his rest more tranquil or more profoundly secure in the hearts of those who love noble deeds."

In the seven years of my life that has been honored with your association, no period has been appreciated more. I have tried at all times to the best of my ability to hold our standard high. I have made mistakes like all of you, something common to humanity. I stand for better medical education. The meetings of this society have been a school for me, as well as you, each gathering some good at the times that we have met.

Gentlemen, since you saw fit to choose me as president of the society for this calendar year of nineteen hundred and nine, I assure you that the honor has been greatly appreciated. I had aspired to this honor since being a member of the society, and at the same time felt a hesitancy as to my filling the office as it should be filled. You have been patient with my ruling, which at all times has been in accord with a majority of those present. We have endeavored to interest the society with some ideas that I trust it may see fit to put into operation.

We have seen through recent legislatures what medical influence can do, the passage of several very important bills. What has done this? The organization of this great profession, thrusting the harpoon at the charlatan. He who is not abreast with the progress of the profession, is not worthy of the high calling. Our society is largely what we make it, and we have one great fault that can be remedied, it lies within the help and influence of each individual member,—it is attendance. What professional brother is in the society who cannot set aside or arrange his work so that he can be off the few hours of this meeting once a month, twelve times a year?

Were it for twenty-five dollars I dare say that there would be but few of us missing. You doubtless will say that was the reason, but in a large per cent. of the cases we know better. Could you not arrange to come even six times a year? And would you think it possible that some who have their names on our roster thus entitling them to all the privileges of membership of the society, have never entered our halls, nor even given the time they asked of us to ballot upon them as members? If they are so well posted that we can teach them nothing from our meetings, our society would appreciate a paper or lecture from them occasionally. Who knows but that to-morrow's mail will bring the summons of some malpractice suit? The result often from not carrying out our instructions. If you are a member in good standing you will appeal first

to your medical society for help. Could it not be given more willingly if you were one of the active workers?

The day is here when in seeking public appointment pension, insurance or otherwise, one of the first questions before appointment is, "Are you a member of your County and State society and in good standing?" if such bodies recognize such a requirement as being important it seems that we should be up and doing to keep our standard high. Our society has members that any county or city would be proud of. I hope to see the standard bearer of our county equal to any county in grand old Missouri. We have the material, why not put forth the effort? You can help this society by attending. I especially ask of you to come as often as possible.

My professional brothers, our duty is to help one another and by so doing we help ourselves. And now as I turn this gavel over to my successor, I am ever ready to help you and the society in any way that I can be of assistance to the organization. Let us endeavor to make each year better than the ones that have passed.

Let us enroll on our roster every worthy brother in the county. Our teachings and examples will not last long. Soon the death angel will give our call, and we must pass to our eternal home. Some others must fill our places. Keeping in mind always absorbing devotion to the profession you will see a fair example of what I wish to convey in the lines of Burns, "To a Friend."

"To catch Dame Fortune's golden smile,
Assiduous wait upon her;
And gather gear from ev'ry wile,
That's justified by honor;
Not for to hide it in a hedge,
Not for a trained attendant;
But for the glorious privilege
Of being independent."

THYREOID INSTABILITY: WITH REPORT OF A CASE.*

By A. L. CAMBRE, M. D., Atlanta, Mo.

The paucity of literature bearing upon this subject has led me to believe that either the cases representative of this morbid entity are infrequent, or they are not uncommon but are often classed with the "neuroses" or the "toxemias" without due reference to the etiological basis.

With a careful analysis of the typical clinical manifestations the correct diagnosis follows as a logical sequence.

Thyreoid instability is a term applied by Levy and Rothschild to a series of morbid conditions between the extremes of myxedema and exophthalmic goitre. According to their interpretation this is the result of a general law of nature that an organ functioning defectively strives to restore normal balance and when this is reached is liable to go beyond it with exaggerated function.

Conditions may be found in which both deficient and excessive function may be observed in the same case, with or without visible enlargement of the thyreoid gland.

The suddenness of the onset is somewhat characteristic of the paroxysmal nature of this affection and throughout the paroxysm various nervous manifestations are observed.

Patient, Mrs. A.; age 64; occupation, housewife; weight 140 lbs. Paternal history—negative. Family history—negative, except that one sister has enlargement of the thyreoid gland. Married, one child living, in good health; husband dead. Personal history; had the ordinary diseases of childhood with complete recovery in each case. Passed menopause normally. About seven years ago was taken sick rather suddenly with what was called typhoid malaria and was confined to house for about five months. Has had fairly good health since that time to the beginning of present illness, except that she has had some nervous symptoms, at times, but was able to attend to the duties of a household. Present illness; while busy in yard about February 10th last, was suddenly attacked with a feeling of weakness, and tachycardia which was of a tumultuous nature. Was put to bed and physician called who pronounced the condition one of disturbed nervous control and treated her accordingly.

She later developed, in addition to the above symptoms, nausea, vomiting, bitter taste, some constipation, complete anorexia, tongue coated at times, periodical rise of temperature, and still later complained of soreness and tenderness to pressure over pyloric area. She gradually became

*Read at the meeting of the Macon County Medical Society, December, 1909.

weaker and emaciated, taking little nourishment and vomiting nearly every day.

In the belief that a gastric ulcer was present the patient was finally put upon rectal feeding, with an occasional small amount of soup by mouth. This was continued for about ten days prior to my seeing the case, which was May 17th.

Physical Examination, May 17, 1909. Found patient in bed, weak, considerably emaciated, in a position indicating considerable depression; coarse and fine muscular tremors present, some visible enlargement of thyroid gland, eyes normal, absence of Moebius' and Grafe's signs. There were epigastric pulsations, an apparent total loss of body adipose, tongue red on sides but coated in middle somewhat.

Pulsations were 140 to 160 per minute, tumultuous, with phases of intermittency, the tenderness and soreness in region of pylorus still present, exaggerated by suggestion, patient thinking she had carcinoma of stomach. There was a temperature ranging from 100° to 101.5° also intermittent.

Heart was enlarged considerably in transverse diameter; thyroid examination revealed some enlargement of both lateral lobes and also isthmus although this was not marked. Patient explained that this enlargement had existed in about the same degree for thirty-four years, producing no symptoms till the present, when she complained of a feeling of pressure at times during present illness. Examination with stethoscope revealed loud hemic murmurs, distinct bruits with easily palpable pulsations over the gland. Reflexes were exaggerated, nervous symptoms were pronounced, with considerable psychic coloring.

Urine Analysis. Amount—42 oz. Acid, sp. gravity, 1025. Urea—1.9 per cent., no albumen, no sugar, bile salts negative, some indican.

The high per cent. of urea elimination while upon rectal feeding with low nitrogen intake afforded an explanation for the progressive asthenia and emaciation.

The plan of treatment was to provide in an easily digestible form sufficient proteids to maintain nitrogen equilibrium and gradually produce a condition of hypernutrition.

This was accomplished by feeding every three hours at first, later on, more often, the following:

A glass of milk rich in cream into which was broken one egg, flavored to suit; more cream was added and finally as high as three eggs to each glass were used every three hours.

Added to the above in proportion to the digestive capacity of the stomach were the following articles: Ice cream, custard, beef, oatmeal with cream and butter, etc.

The above constituted the dietetic regime.

The drug treatment consisted of the bromides, with 30 gr. twice daily of sodii phosphate to maintain elimination.

The ice bag was kept over the precordium most of the time for awhile as an aid in controlling the tachycardia. A cold water bottle was also placed over the thyroid gland for several hours each day.

The patient made an uneventful recovery; nausea, vomiting, etc., soon disappearing with gradual amelioration of nervous symptoms and tachycardia.

She is to-day in normal flesh and able to assume the activities compatible with her age.

Journal

Missouri State Medical Association.

The Official Organ of the State Association and Affiliated County Societies.
Published Monthly under the supervision of the Publishing Committee.

ADDRESS ALL COMMUNICATIONS TO METROPOLITAN BUILDING, ST. LOUIS, MO.

Volume VI.

MAY, 1910.

Number 11

E. J. GOODWIN, M. D., Editor.

PUBLICATION COMMITTEE:

Walter B. Dorsett, M. D., Chairman.

M. B. Clopton, M. D.

M. C. Shelton, M. D.

EDITORIAL

THE HANNIBAL MEETING.

The Fifty-third Annual Meeting of the Association will convene at Hannibal, May 3, 4 and 5. The President, Dr. Tinsley Brown, has taken a very deep interest in the welfare of the Association and has given a great deal of his time during the year to traveling over the State, addressing the county societies and by all other means at his command bringing every influence to bear upon the members and the county societies to foster and maintain an active interest in the organization. As a result of this good work we look for a large attendance at the coming session.

The program, which is published in this issue, is very attractive and shows that the program committee has given earnest attention to its preparation, and particularly to the practical value of the subjects to be discussed.

A departure has been made from the custom hitherto followed since the establishment of section meetings which will be highly appreciated by those who attend. In previous years all papers were read in the sections and it frequently happened that members were prevented from hearing certain papers which held special interest for them read in one section whilst they were listening to papers of equal interest, presented in another section. This year the program committee has arranged for

several general sessions during which those papers that treat of subjects which concern the practitioner, irrespective of the specialty practiced, will be read. In these general sessions, also, several committees of the House of Delegates will read their reports, since they touch upon certain phases of the practice of medicine in which all physicians are interested. These reports will include the Committees on Tuberculosis, Ophthalmia Neonatorum, Public Policy and Legislation, Defense Committee, Council on Medical Education, Committee on Medical Expert Testimony, and the Committee on Cancer.

The general meetings will be held in the Assembly Room on the third floor of the Mathew-Columbus Building, the Eye, Ear, Nose and Throat Section will meet on the second floor of the same building, and the Surgical Section will hold its sessions in the Commercial Club rooms, adjoining the Mathew-Columbus Building.

REDUCED RAILROAD RATE TO HANNIBAL.

Efforts are being made to secure a reduction in the railroad fare to Hannibal and return. At the time of going to press nothing definite has been accomplished, but it is probable that the railroads will authorize a rate of one and one-third fare for the round trip.

Members attending the meeting are requested to ask the ticket agent to give them certificates showing the purchase of tickets. If a special rate is allowed, this certificate will entitle the member to a reduction in the fare on the return trip. Those members who find it necessary to change cars en route must secure certificates from each ticket agent from whom tickets are purchased.

A HOSPITAL COMMISSION FOR ST. LOUIS.

St. Louis has recently adopted a modern system of management of its eleemosynary institutions which will, if the intent of the ordinance is fully carried out, attract medical men of high professional standing and large experience to positions on the visiting staff. It will dissociate all hospitals from political influence of any kind and greatly improve the conditions affecting the medical and surgical care of the sick, while adding immensely to the teaching facilities of the medical colleges.

The ordinance provides for the establishment of a hospital board

of five members, not more than one of whom shall be from the same medical college, and of a hospital commissioner. The hospital board will be appointed by the Mayor, and the board will appoint the hospital commissioner. The business management of the hospitals will be conducted by superintendents, but the medical care of the patients will be placed in the control of the visiting staff of physicians to be appointed by the hospital board. The resident staff of physicians will be salaried and perform their duties under the direction of the visiting staff. Thus, the inmates of the hospitals will receive far better attention than it was possible to give them under the old method, and the medical profession of St. Louis will be afforded the opportunity of performing a service to the community which it would be impossible to consummate under a less liberal control of the medical affairs of the institutions.

INFORMATION WANTED CONCERNING THE MATERIAL AFFAIRS OF THE MEMBERS.

On another page we publish a list of questions which the committee on public policy and legislation desire shall be answered by each member. The object of gathering this information concerning the doctor is for the purpose of collecting statistics upon which to base certain plans to improve the financial outlook of the practicing physician. At present we have no data whatever concerning the status of the profession of the State as a class, but the Association ought to have this information in its records, that firm grounds might be established upon which to base intelligent and effective action to improve the material welfare of the members, if possible to do so. If the members will answer the questions, tear out the blank and mail to the secretary, we shall soon have statistical information of the highest value in guiding the officers to devise definite plans for the end indicated. No names are to be signed to the blanks. ..

SCIENTIFIC EXHIBITS OF THE AMERICAN MEDICAL ASSOCIATION.

The local committee on Scientific Exhibits for the St. Louis session of the American Medical Association is making extensive preparations for the liberal contributions which will be made by medical institutions and individual members of the profession to this department. The Scientific Exhibit has grown to be one of the most interesting and in-

structive features of the annual meetings. At this writing the following institutions have applied for space: St. Louis Health Department, St. Louis University Medical Department, St. Louis Skin & Cancer Hospital, Medical Department Washington University, St. Louis Medical History Club, Medical Department of the University of Missouri, State Pure Food and Drug Commissioner, State Veterinarian, State Board of Health, Public Recreation Commission of St. Louis, the St. Louis Anti-Tuberculosis Society, and many individuals.

MORE NEWSPAPER NOTORIETY.

We are asked to publish the following items which appeared in St. Joseph newspapers recently, and we do so with the hope that the offending physicians will not permit their names to appear in connection with articles of this character in future. The excerpts of objectionable articles published in previous issues of the JOURNAL have had a salutary effect, for members are becoming exceedingly careful about permitting their names to be published in connection with news items in newspapers relating to the treatment of persons under their care. The Council will soon take more drastic steps if members persist in pursuing such unworthy practices, and order the name of the doctor published in the JOURNAL. The objectionable articles follow:

PERFORM UNUSUAL OPERATION.

One of the rarest operations ever performed by surgeons in this part of the country, and the only one on record at the local hospitals, was performed Thursday, March 31st, at ——— hospital by Dr. ———, assisted by Dr. ——— and Dr. ———. A woman about 28 years old was operated upon, the object being to remove an abnormal growth on the abdomen.

An incision was made over the abdomen and from twelve to fifteen pounds of fat, without any muscle, was removed. The incision was made to the muscle and the entire layer of fat was eliminated. * * * The woman is able to sit up and will be removed from the hospital in a few days. * * * The case is being watched with much interest both by the attending physicians and the hospital authorities.—(St. Joseph Gazette.)

BLIND FROM BIRTH NOW SEES.

George Chiles walked out of ——— hospital the happiest of individuals yesterday afternoon * * *. George came here some weeks ago for treatment of a blindness which had existed in both eyes since birth, twenty-one years ago. He was operated upon before the students of the ——— college and since then has been a wonder to the other patients at the hospital. * * * From a hopeless burden upon others he will now become self-sustaining. Dr. ——— performed the operation.—(St. Joseph News-Press.)

FREE DENTAL CLINICS FOR PUBLIC SCHOOLS.

The St. Louis Dental Society has volunteered to establish free dental clinics in the Public Schools in St. Louis and place a competent dentist in charge to inspect and care for the teeth of the children. The offer has been accepted by the Board of Education. The first clinic will be opened in the building of the Board of Education at 9th and St. Charles streets and if the experiment proves successful other clinics will be established in the various school districts—and successful it will prove. Before very long the limousines and electric cars will carry the children from the avenues inhabited by our aristocracy to the free clinic, have their teeth cleaned and placed in æsthetic rows, for nothing. With free books, free doctors, free tooth carpentering, we need only a free millinery department to make the parental government more assured.

The large number of struggling dentists throughout the city, who would cheerfully give their services to the worthy poor, will find, with the opening of free dental clinics at the schools, the opportunity for securing bread and butter still more rare than it is at present. But we are drifting toward socialism!

TRAINING SCHOOL FOR BABIES' NURSES.

The managers of the St. Louis Children's Hospital have decided to establish a training school for babies' nurses in connection with the hospital work. There is a need for such a school in every large city. Parents are often compelled to trust their infants in the hands of ignorant young girls, concerning whose disposition, cleanliness or habits they have little or no knowledge. The school will prove a real benefit to the public and should receive the endorsement of the medical profession.

THE BUTTON.



Don't neglect to buy a Missouri State Medical Association button. It will be on sale at the registration bureau. Price one dollar. Every member ought to possess this button for it is an insignia of fellowship that all should be proud to display.

AMERICAN MEDICAL ASSOCIATION NEWS.

HOTELS AT ST. LOUIS.

Rates, Locations and Capacities of Hotels for the St. Louis Session.

Members of the American Medical Association desiring to secure hotel accommodations should write to the chairman of the Hotels Committee, Dr. Louis H. Behrens, 609 Metropolitan Building, or direct to the hotels. Many reservations have already been made and prompt attention should be given to this matter in order to secure accommodations in advance.

When writing, please give definite instructions as to the character of rooms desired, whether with or without bath, European or American plan, number of people in the party, and particularly the names of persons who are willing to share rooms.

As the section meeting places are located along Grand avenue, which is a thoroughfare about midway between the east and west ends of the city, the hotels are listed according to their location, and the time consumed in riding to the meeting-places is mentioned.

The first list comprises those hotels located in the downtown, or east, section of the city:

AMERICAN HOTEL, Seventh and Market Sts., 275 rooms, all with bath; can take 350; rate, one person, \$1.50 and up; additional, \$1 per person; 15 minutes from meeting place.

EDISON HOTEL, 107 N. Eighth St., 12 rooms; can take 24; rate, one person, \$1; additional, \$1 per person; 15 minutes from meeting place.

HOTEL GARNI, Jefferson and Olive Sts., 50 rooms; can take 50; rate, one person, \$0.75 and up; additional, \$0.50 per person; 8 minutes from meeting place; near Coliseum.

JEFFERSON HOTEL, Twelfth and Locust Sts., 400 rooms; can take 300; rate, one person, \$1.50 and up; with bath, \$2.50 and up; additional, \$1 per person; with bath, \$1.50 per person; 8 minutes from meeting place.

LACLEDE HOTEL, Sixth and Chestnut Sts., 170 rooms; can take 150; rate, one person, \$1 and \$1.50; with bath, \$2 to \$2.50; additional, \$1 per person; 15 minutes from meeting place.

MADISON HOTEL, Broadway and Chestnut Sts., 112 rooms; can take 100; rate, one person, \$1 and up; additional, \$0.75 and up; 15 minutes from meeting place.

MARQUETTE HOTEL, Eighteenth and Washington Ave., 400 rooms; can take 250; rate, one person, \$1.50 and up; with bath, \$2 and up; additional, \$1 per person; 8 minutes from meeting place.

MARYLAND HOTEL, Ninth and Pine Sts., 240 rooms; can take 200; rate, one person, \$1 to \$2; with bath, \$2 to \$2.50; additional, \$1 per person; 10 minutes from meeting place.

MOSER HOTEL, 809 Pine St., 100 rooms; can take 75; rate, one person, \$0.75 and \$1; additional, \$0.75 per person; 10 minutes from meeting place.

PLANTERS HOTEL, Fourth and Fine Sts., 440 rooms; can take 300; rate, one person, \$1.50 and up; with bath, \$2.50 and up; additional, \$1 per person; with bath, \$1.50 per person; 15 minutes from meeting place.

PORTLAND HOTEL, 1817 Market St., 100 rooms; can take 100; rate, one person, \$1; additional, \$0.75 per person; 10 minutes from meeting place.

- ROZIER HOTEL, Thirteenth and Olive Sts., 120 rooms; can take 180; rate, one person, \$0.75 to \$1.50; additional, \$0.75 per person; 8 minutes from meeting place.
- ST. JAMES HOTEL, Broadway and Walnut, 150 rooms; can take 200; rate, one person, \$1.50; with bath, \$2; additional, \$1 per person; with bath, \$1.50 per person; 15 minutes from meeting place.
- ST. NICHOLAS HOTEL, Broadway and Market, 40 rooms; can take 25; rate, one person, \$0.75 to \$1; additional, \$0.50 per person; 15 minutes from meeting place.
- SOUTHERN HOTEL (General Headquarters), Broadway and Walnut, 400 rooms; can take 200; rate, European plan, one person, \$1.50 and up; with bath, \$2.50 and up; American plan, one person, \$3.50 and up; with bath, \$4 and up; additional, European plan, \$1.50 and up per person; American plan, \$3.50 and up per person; 15 minutes from meeting place.
- STRATFORD HOTEL, Seventh and Pine Sts., 100 rooms; can take 150; rate, one person, \$1; with bath, \$1.50; additional, \$0.50 per person; 15 minutes from meeting place.
- TERMINAL HOTEL, Union Station, 110 rooms; can take 150; rate, one person, \$1.25 and up; with bath, \$2.50 and up; additional, \$1.25 per person; 10 minutes from meeting place.

The following hotels are located in the West End, or residence section, of the city:

- BEERS HOTEL, Grand and Olive, can take 40; rate, one person, \$1 and up; with bath, \$2.50 and up; additional, \$1 per person; at meeting place.
- BUCKINGHAM HOTEL, Kingshighway and West Pine, can take 100; rate, one person, European plan, \$1.50; with bath, \$2.50; additional, \$1 per person; rate, one person, American plan, \$3; with bath, \$4; additional, \$2.50 per person; 10 minutes from meeting place.
- HAMILTON HOTEL, Hamilton and Maple Ave., 150 rooms; can take 50; European plan, rate, one person, \$1; with bath, \$1.50; additional, \$1 per person; American plan, one person, \$2; with bath, \$2.50; additional, \$1.50; 15 minutes from meeting place.
- HOTEL BERLIN, Berlin and Taylor Aves., can take 25; American plan, rate, one person, \$1.50; with bath, \$2.50; additional, \$1 per person; 10 minutes from meeting place.
- USONA HOTEL, Kingshighway and McPherson, 100 rooms; can take 50; American plan, rate, one person, \$2.50; with bath, \$3; additional, \$1.50 per person; with bath, \$2 per person; 10 minutes from meeting place.
- WEST END HOTEL, Vandeventer and W. Belle, can take 25; rate, one person, \$1 and up; with bath, \$1.50 and up; additional, \$1 and up; 5 minutes from meeting place.
- WESTMORELAND HOTEL, Maryland and Newstead Aves., can take 50; all rooms with bath; rate, one person, \$2; additional, \$1 per person; 8 minutes from meeting place.
- WINDERMERE HOTEL, 5601 Delmar Blvd., American plan only; can take 25; rate, one person, \$1.50; with bath, \$2.50; additional, \$1 per person; 15 minutes from meeting place.

PRIVATE HOMES AND BOARDING HOUSES.

In addition to the hotels listed there are numerous private homes and boarding-houses on and near Grand avenue, in close proximity to the section meeting-places, where good accommodations can be secured at rates ranging from 75 cents to \$1.50 a day, American plan. Those who desire to obtain such accommodations should write to the chairman, Hotels Committee, at the address given above. State clearly what accommodations are desired, for how many people, and at what rate per day.

The street car facilities are most excellent, cars running at two and three minute intervals, and arrangements are being made for special service on occasions when the members will travel in large bodies at any particular hour. Taxicabs will also be at hand, and a special rate will be allowed for transporting the members from the Coliseum, where the Registration Bureau will be established, to the Grand avenue district.

The section and other meeting places are as follows:

MEDICINE: Third Baptist Church, Grand and Washington Aves.

SURGERY: Odeon Theatre, Grand and Finney Aves.

OBSTETRICS AND DISEASES OF WOMEN: Y. M. C. A. Building—Association Hall, Grand and Franklin Aves.

LARYNGOLOGY AND OTOTOLOGY: Sodality Hall, Grand Ave., between Pine and Laclede.

OPHTHALMOLOGY: Aschenbroedel Hall, Pine St., east of Grand Ave.

DISEASES OF CHILDREN: Grand Avenue Presbyterian Church, Sunday School Room, Grand and Washington Aves.

PHARMACOLOGY AND THERAPEUTICS: Delmar Avenue Congregational Church, Delmar, west of Grand Ave.

STOMATOLOGY: Y. M. C. A. Building—Small Hall, Grand and Franklin Aves.

NERVOUS AND MENTAL DISEASES: St. Louis University Library, Grand Ave., head of East Pine.

DERMATOLOGY: Odeon Building—Recital Hall, Grand and Finney Aves.

PREVENTIVE MEDICINE AND PUBLIC HEALTH: Knights of Culumbus Building, Olive St., east of Grand Ave.

PATHOLOGY AND PHYSIOLOGY: Y. M. C. A. Building—Lecture Hall, Grand and Franklin.

SCIENTIFIC AND COMMERCIAL EXHIBITS, POSTOFFICE, REGISTRATION OFFICE: Coliseum, Washington and Jefferson.

PRESIDENT'S RECEPTION: First Regiment Armory, Grand and Manchester Aves.

GENERAL SESSION: Odeon Theatre, Grand and Finney Aves.

HOUSE OF DELEGATES: St. Louis Medical Society, Pine St., east of Grand Ave.

The Committee on Section Meeting Places will endeavor to have all hall fully equipped with every needed appurtenance to facilitate the transaction of the work of the sections. Communications on this subject should be addressed to Dr. H. Tuholske, Chairman of the Committee on Section Meeting Places, 609 Metropolitan Building, St. Louis.

NEW MEMBERS

ADAIR COUNTY.

Parrish, A. W., Kirksville, Mo.
Rankin, H. Johnson, Kirksville, Mo.

ANDREW COUNTY.

Jeffries, Elmer C., Whitesville, Mo.
Wood, W. Logan, Bolckow, Mo.

ATCHISON COUNTY.

McBride, George W., Tarkio, Mo.

AUDRAIN COUNTY.

Bland, W. W., Vandalia, Mo.
Blanks, Charles L., Mexico, Mo.
Diven, Thomas H., Martinsburg, Mo.

BARRY COUNTY.

Robertson, J. S., McDowell, Mo.
Dummitt, Manford, Jenkins, Mo.

BATES COUNTY.

Martin, Charles F., Amsterdam, Mo.
Tuttle, Henry W., Adrian, Mo.

BENTON COUNTY.

Bay, Harry, Colecamp, Mo.

BUTLER COUNTY.

Davidson, A. W., Poplar Bluff, Mo.
Hayhurst, J. O., Poplar Bluff, Mo.

CALDWELL COUNTY.

Meredith, O. O., Breckenridge, Mo.

CASS COUNTY.

Chaffin, S. E. Barnes, Belton, Mo.
Dodd, C. S., Garden City, Mo., R. F. D.
Fair, S. W., Belton, Mo.
Scott, J. U., Harrisonville, Mo.

CLINTON COUNTY.

McDonald, E. S., Cameron, Mo.
Longfield, Fred, J., Lathrop, Mo.
Janes, Vincil B., Cameron, Mo.
Kimsey, J. T., Lathrop, Mo.
Risley, C. H., Cameron, Mo.
Starks, John Charles, Gower, Mo.

COOPER COUNTY.

Hurt, Peyton L., Boonville, Mo.

GENTRY COUNTY.

Smith, George W., Albany, Mo.

HOLT COUNTY.

Hogan, Joseph L., Forbes, Mo.
Thatcher, J. T., Oregon, Mo.

HOWELL COUNTY.

Andrews, T. P., Mount View, Mo.
Williams, Jesse P., Mount Grove, Mo.

JACKSON COUNTY.

King, George A., 415 Argyle Bldg.
Mays, H. C., 520 Commerce Bldg.
Royer, Elliott, 3100 Euclid Ave.
Weiss, F. H., 27th & Benton Bl.
Robinson, G. Wilse, Argyle Bldg.

JOHNSON COUNTY.

Draper, Thomas J., Warrensburg, Mo.

LACLEDE COUNTY.

Caldwell, Thomas A., Lebanon, Mo.
Carlton, Charles E., Stoutland, Mo.
Cooce, George W., Conway, Mo.
Crawford, John R., Phillipsburg, Mo.
Summers, W. R., Conway, Mo.

LAFAYETTE COUNTY.

Clayton, Paul B., Odessa, Mo.
Tucker, Joseph E., Lexington, Mo.

LAWRENCE-STONE COUNTY.

Ament, W. F., Aurora, Mo.

LEWIS COUNTY.

McKim, John V., Newark, Mo.
O'Neal, W. C., LaGrange, Mo.

MACON COUNTY.

Belyea, J. H., Ardmore, Mo.
Sexaner, C. F., Keota, Mo.
West, C. O., New Cambria, Mo.

MARION COUNTY.

Ross, Mary S., Hannibal, Mo.

MISSISSIPPI COUNTY.

Boone, J. C., Charleston, Mo.
Davis, J. S., East Prairie, Mo.
Hodges, D. M., East Prairie, Mo.
Marshall, A. H., Charleston, Mo.
Tarr, G. H., Belmont, Mo.
Vernon, F. S., Charleston, Mo.

MONTGOMERY COUNTY.

Foreman, James Milton, Jonesburg, Mo.

PHELPS COUNTY.

Pinto, Jack, St. James, Mo.

PULASKI COUNTY.

Von Gremp, Henry J., Dixon, Mo.

PUTNAM COUNTY.

Vores, Cyril Preson, Unionville, Mo.

RALLS COUNTY.

Welsch, John A., Harrisonville, Mo.

RIPLEY COUNTY.

Byrd, William M., Oxly, Mo.
White, Homer T., Oxly, Mo.

SCHUYLER COUNTY.

Hight, Wm. B., Queen City, Mo.

SHELBY COUNTY.

Devin, James F., Shelbyville, Mo.

ST. LOUIS COUNTY.

Hanson, H., Desperes, Mo.

ST. LOUIS MEDICAL SOCIETY.

Goodman, Daniel C., 309 Century Bldg.
Mueller, Ernst H., 3548 Arsenal St.

VERNON COUNTY.

Hornbeck, J. T., Nevada, Mo.
Petty, George W., Nevada, Mo.
Walker, G. S., Harwood, Mo.
Rooks, O. R., Nevada, Mo.

Fifty-Third Annual Meeting
MISSOURI STATE MEDICAL ASSOCIATION
Hannibal, May, 3, 4 and 5, 1910

OFFICERS, 1909-10

PRESIDENT.

TINSLEY BROWN, M. D. Hamilton

VICE-PRESIDENTS.

J. M. BELL, M. D. St. Joseph

J. A. HARRIS, M. D. Mt. Vernon

H. G. SHOBE, M. D. Paris

B. W. HAYS, M. D. Jackson

*J. L. THORPE, M. D. Jefferson City

SECRETARY.

A. W. MCALESTER, JR., M. D. Kansas City

TREASURER.

J. FRANKLIN WELCH, M. D. Salisbury

MEDICAL SECTION.

Chairman: FRANKLIN E. MURPHY, M. D. Kansas City

Secretary: W. R. PATTERSON, M. D. Tipton

SURGICAL SECTION.

Chairman: WILLARD BARTLETT, M. D. St. Louis

Secretary: LEO RASSIEUR, M. D. St. Louis

EYE, EAR, NOSE AND THROAT SECTION.

Chairman: JOHN GREEN, JR., M. D. St. Louis

Secretary: CLARENCE LOEB, M. D. St. Louis

ORATORS.

Oration on Medicine: N. P. WOOD, M. D. Independence

Oration on Surgery: FRANCIS REDER, M. D. St. Louis

COMMITTEE ON SCIENTIFIC WORK.

FRANKLIN E. MURPHY, M. D. LEO RASSIEUR, M. D.

W. R. PATTERSON, M. D. JOHN GREEN, JR., M. D.

WILLARD BARTLETT, M. D. CLARENCE LOEB, M. D.

PUBLICATION COMMITTEE.

W. B. DORSETT, M. D., Chairman.

M. B. CLOPTON, M. D. M. C. SHELTON, M. D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

R. M. FUNKHOUSER, M. D., Chairman.

M. P. OVERHOLSER, M. D. C. R. DUDLEY, M. D.

DEFENSE COMMITTEE.

F. J. LUTZ, M. D., Chairman.

W. B. DORSETT, M. D. JOSEPH GRINDON, M. D.

COUNCIL ON MEDICAL EDUCATION.

B. M. HYPES, M. D., Chairman.

C. M. JACKSON, M. D. C. LESTER HALL, M. D.

COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS.

JABEZ N. JACKSON, M. D., Chairman.

F. B. HILLER, M. D. FRANK R. FULTON, M. D.

COMMITTEE ON TUBERCULOSIS.

E. W. SCHAUFFLER, M. D., Chairman.

GEORGE HOMAN, M. D. JAMES McCOMB, M. D.

C. M. McCONKEY, M. D. JAMES HANKS, M. D.

COMMITTEE ON MEDICAL EXPERT TESTIMONY.

W. B. OUTTEN, M. D., Chairman.

W. H. MCGILL, M. D. JOHN ASHLEY, M. D.

COMMITTEE ON OPHTHALMIA NEONATORUM.

M. HAYWARD POST, M. D., Chairman.

J. C. SHELTON, M. D. GUY TITSWORTH, M. D.

COMMITTEE ON CANCER.

F. J. LUTZ, M. D., Chairman.

J. F. BINNIE, M. D. FRANK HALL, M. D.

*Deceased.

DELEGATES

COUNTY.	DELEGATE.	ALTERNATE.
Adair.	E. C. Callison.	
Atchison.	J. W. Holliday.	
Barry.	A. S. Hawkins.	D. E. Miller.
Barton.	A. B. Stone.	
Benton.	W. G. Jones.	H. G. Savage.
Buchanan.	{ A. B. McGlothlan.	H. S. Forgrave.
	{ C. A. Good.	
Caldwell.	C. L. Woolsey.	W. T. Lindley.
Cape Girardeau.	R. F. Wichterich.	
Cass.	R. S. Crawford.	H. Jerard.
Cedar.	R. B. Marr.	Kimball Hill.
Christian.	J. A. Robertson.	J. C. Young.
Dent.	J. C. Welch.	W. E. Rudd.
Henry.	A. McNeas.	
Howard.	Joel Y Hume.	
Howell.	D. J. Nichols.	
Jasper.	R. M. James.	J. W. Clark.
Jefferson.	R. E. Donnell.	I. N. McNutt.
Johnson.	D. E. Shy.	
Livingston.	H. M. Grace.	
Madison.	S. C. Slaughter.	C. U. Davis.
Marion.	T. A. Roselle.	E. T. Hornback.
Miller.	W. S. Allee.	
Mississippi.	J. W. Lynch.	A. W. Chapman.
Moniteau.	H. C. Freudenberger.	W. R. Patterson.
Monroe.	D. W. McGee.	
Montgomery.	C. A. Revelle.	W. M. Wheeler.
Phelps.	S. L. Baysinger.	W. S. Smith.
Randolph.	C. B. Clapp.	F. L. McCormick.
Ray.	Herman S. Major.	James. W. Smith.
	J. H. Amerland.	Wm. E. Sauer.
	Willard Bartlett.	Albert F. Koetter.
	Walter Baumgarten.	Warren P. Elmer.
	Louis H. Behrens.	E. Lee Dorsett.
	Vilray P. Blair.	Geo. Homan.
	Malvern B. Clopton.	
St. Louis City.	Geo. C. Crandall.	
	Joseph Grindon.	
	William W. Graves.	Paul Y. Tupper.
	Louis H. Hempelmann.	Wm. G. Moore.
	Thomas A. Hopkins.	F. J. Taussig.
	Herman L. Nietert.	Horace W. Soper.
	Walter C. G. Kirchner.	
	Louis Rassieur.	Wm. H. Luedde.
Ste. Genevieve.	J. A. Wilkins.	
Scott.	Roy Frazer.	
Schuyler.	J. B. Bridges.	
Webster.	W. J. Rabenau.	T. S. Burton.

Councilor Districts and Counties in Each District*

- F. J. Lutz, St. Louis, Chairman. E. J. Goodwin, St. Louis, Secretary.
- First District—Councilor, C. L. Evans, Oregon. Counties: Holt, Atchison, Nodaway.
- Second District—Councilor, W. T. Elam, St. Joseph. Counties: Buchanan, Andrew.
- Third District—Councilor, G. W. Whitely, Albany. Counties: Harrison, Worth, Gentry, DeKalb.
- Fourth District—Councilor, C. R. Buren, Princeton. Counties: Grundy, Sullivan, Mercer, Putnam.
- Fifth District—Councilor, E. E. Parrish, Memphis. Counties: Clark, Scotland, Schuyler.
- Sixth District—Councilor, H. Jurgens, Edina. Counties: Adair, Knox, Lewis.
- Seventh District—Councilor, R. H. Goodier, Hannibal. Counties: Shelby, Marion, Ralls.
- Eighth District—Councilor, Walter B. Dorsett, St. Louis. Counties: Lincoln, St. Charles, St. Louis, Pike.
- Ninth District—Councilor, A. R. McComas, Sturgeon. Counties: Audrain, Boone, Howard, Callaway, Warren, Montgomery.
- Tenth District—Councilor, C. W. Reagan, Macon. Counties: Macon, Randolph, Monroe.
- Eleventh District—Councilor, J. D. Brummall, Salisbury. Counties: Chariton, Carroll, Livingston, Linn.
- Twelfth District—Councilor, E. H. Miller, Liberty. Counties: Platte, Clay, Ray, Clinton, Caldwell, Daviess.
- Thirteenth District—Councilor, F. E. Murphy, Kansas City. County: Jackson.
- Fourteenth District—Councilor, C. T. Ryland, Lexington. Counties: Lafayette, Saline, Cooper.
- Fifteenth District—Councilor, J. A. Anderson, Warrensburg. Counties: Cass, Johnson.
- Sixteenth District—Councilor, J. R. Buchanan, Nevada. Counties: Bates, Vernon, Barton.
- Seventeenth District—Councilor, R. D. Haire, Clinton. Counties: Pettis, Henry, Benton, St. Clair, HICKORY.
- Eighteenth District—Councilor, Frank DeVilbiss, Eugene. Counties: Miller, Moniteau, Morgan, Camden.
- Nineteenth District—Councilor, G. Ettmueller, Jefferson City. Counties: Cole, Osage, Maries, Gasconade.
- Twentieth District—Councilor, F. J. Lutz, St. Louis. Counties: Franklin, St. Louis City.
- Twenty-first District—Councilor, G. M. Rutledge, Ste. Genevieve. Counties: Jefferson, Ste. Genevieve, Perry.
- Twenty-second District—Councilor, W. S. Hutton, Fomfelt. Counties: Scott, Madison, Cape Girardeau, Mississippi, BOLLINGER.
- Twenty-third District—Councilor, T. C. Allen, Bernie. Counties: Stoddard, Dunklin, Pemiscot, New Madrid.
- Twenty-fourth District—Councilor, T. W. Cotton, Van Buren. Counties: Wayne, Ripley, Butler, Carter.

Councilor Districts and Counties in Each District*

Twenty-fifth District—Councilor, C. R. Fleming, Farmington: Counties: Washington, Reynolds, Iron, St. Francois.

Twenty-sixth District—Councilor, W. H. Bruere, Rolla. Counties: Crawford, Phelps, Pulaski, Laclede, Dent, DALLAS.

Twenty-seventh District—Councilor, H. C. Shuttee, West Plains. Counties: Howell, Shannon, OZARK, OREGON, TEXAS, WRIGHT, DOUGLAS.

Twenty-eighth District—Councilor, A. H. Madry, Aurora. Counties: Greene, Lawrence, Barry, Stone, Christian, Webster, Polk, Taney.

Twenty-ninth District—Councilor, R. L. Neff, Joplin. Counties: McDonald, Newton, Jasper, Cedar, DADE.

**Counties in small capitals are not organized.*

NOTICE

All members will please register with the Registration Committee immediately upon arrival.

Sessions will be called to order at the hour fixed on the program. It is especially desired that the members be prompt in their attendance.

All papers must be typewritten and should be handed to the Secretary of the Section as soon as read.

No paper will be allowed to occupy more than twenty minutes in its reading. In the discussion, no member shall speak longer than five minutes, nor more than once on the same subject.

If the author of any paper does not respond when his name is called, his paper takes a place at the end of the program.

The County Secretaries' Association will meet at 4:30 o'clock, and continue in session during the afternoon; dinner being served at six o'clock.

Meeting Places

Mathew-Columbus Building.

House of Delegates meets in Assembly Hall.

Judicial Council meets in Committee Room, second floor.

Medical Section meets in Assembly Hall.

Surgical Section meets in Commercial Club.

Eye, Ear, Nose and Throat Section meets in Committee Room, second floor, Mathew-Columbus Building.

Hotel Rates

The following is a list of the hotels at Hannibal with the rates per day:

Mark Twain Hotel (Headquarters), American plan, \$2 to \$3 per day.

Conklin Hotel, American plan, \$2 per day.

Kettering Hotel, American plan, \$2 per day.

Windsor Hotel, European plan, 50c to \$1 per day.

Union Depot Hotel, European plan, 50c to \$1 per day.

Program

GENERAL SESSIONS

Mathew-Columbus Building

[Assembly Hall]

TUESDAY, MAY 3d—7:30 P. M.

Address of President.....TINSLEY BROWN, M. D., Hamilton

Address.....

B. S. WARREN, M. D., Past Asst. Surg., U. S. P. H. and M. H. S., St. Louis

Oration on Medicine.....N. P. WOOD, M. D., Independence

Oration on Surgery.....FRANCIS REDER, M. D., St. Louis

Assembly Hall

WEDNESDAY, MAY 4th—9:00 A. M.

Reading of papers. See page 751.

WEDNESDAY, MAY 4th—7:00 P. M.

Reading of papers. See page 751.

Assembly Hall

THURSDAY, MAY 5th—9:00 A. M.

Election of President.

Election of Orator on Medicine.

Election of Orator on Surgery.

Reports of Special Committees:

Committee on Tuberculosis.

Committee on Ophthalmia Neonatorum.

Committee on Cancer.

Committee on Public Policy and Legislation.

Committee on Legal Defense.

Council on Medical Education.

Committee on Medical Expert Testimony.

PROGRAM

HOUSE OF DELEGATES.

FIRST DAY—TUESDAY, MAY 3d—9 A. M.

House of Delegates called to order at 9:00 a. m.

Judicial Council meets at call of Chairman.

Roll call.

Reading of minutes of previous meeting.

Reading of President's message and recommendations.

Report of Committee on Arrangements.

Report of Committee on Medical Education.

Report of Committee on Scientific Work.

Report of Committee on Public Policy and Legislation.

Report of Publication Committee.

Report of Special Committees.

Report of Secretary.

Report of Treasurer.

Appointment of Committee on Nominations.

Election of Delegates to American Medical Association. (Three to elect to serve two years.)

Proposed amendments to the Constitution and By-Laws.

Reading of Resolutions, Memorials, etc.

Selection of place of meeting.

Miscellaneous business.

Report of Councilors

1st District.....	C. L. Evans, Oregon
2nd District.....	W. T. Elam, St. Joseph
3rd District.....	G. W. Whitely, Albany
4th District.....	C. R. Buren, Princeton
5th District.....	E. E. Parrish, Memphis
6th District.....	H. Jurgens, Edina
7th District.....	R. H. Goodier, Hannibal
8th District.....	W. B. Dorsett, St. Louis
9th District.....	A. R. McComas, Sturgeon
10th District.....	C. W. Reagan, Macon
11th District.....	J. D. Brummall, Salisbury
12th District.....	E. H. Miller, Liberty
13th District.....	F. E. Murphy, Kansas City
14th District.....	C. T. Ryland, Lexington
15th District.....	J. A. Anderson, Warrensburg
16th District.....	J. R. Buchanan, Nevada
17th District.....	R. D. Haire, Clinton
18th District.....	Frank DeVilbiss, Eugene
19th District.....	G. Ettmueller, Jefferson City
20th District.....	F. J. Lutz, St. Louis
21st District.....	G. M. Rutledge, Ste. Genevieve
22nd District.....	W. S. Hutton, Farnfeld
23rd District.....	T. C. Allen, Bernie
24th District.....	T. W. Cotton, Van Buren
25th District.....	C. R. Fleming, Farmington
26th District.....	W. H. Bruere, St. James
27th District.....	H. C. Shuttee, West Plains
28th District.....	A. H. Madry, Aurora
29th District.....	R. L. Neff, Joplin

GENERAL SESSION

Assembly Hall

SECOND DAY—WEDNESDAY, MAY 4th, 1910.

MORNING SESSION—9:00 O'CLOCK.

1. Some Considerations in the Examination of Children.....
.....H. S. Marsh, M. D., Tipton
2. The Effect of Adenoids and Diseased Tonsils Upon the General
Health.....W. B. Post, M. D., Carthage
3. Diffuse Dilatations of the Esophagus.....
.....C. C. Conover, M. D., Kansas City
4. Clinical Significance of Epigastric Symptoms.....
.....H. C. Crowell, M. D., Kansas City
5. Secondary Gastric Manifestations in Chronic Appendicitis.....
.....Jesse S. Myer, M. D., St. Louis
6. Conditions Affecting the Functions of the Biliary Apparatus
Which Demand Surgical Interference.....
.....Louis J. Dandurant, M. D., St. Joseph
7. What Shall We Do With Patients With Advanced Uterine Cancer?
.....Frank Hinchey, M. D., St. Louis
8. On Fallacies in the Understanding of Antiseptics.....
.....Marsh Pitzman, M. D., St. Louis
9. Surgical Suggestions.....T. F. Lockwood, M. D., Butler
10. The Treatment of Trifacial Neuralgia by Deep Injections.....
.....Vilray P. Blair, M. D., St. Louis
11. Carbuncles: Etiology and Treatment.....
.....William Frick, M. D., Kansas City
12. Syphilis Insontium.....Halsey M. Lyle, M. D., Kansas City

EVENING SESSION—7:00 O'CLOCK.

1. X-Ray Localization of Foreign Bodies.....
.....R. D. Carman, M. D., St. Louis
2. Fulguration in the Treatment of Cancer.....
.....F. J. Lutz, M. D., St. Louis
3. The Clinical Recognition of the Scaphoid Type of Scapula and
Some of Its Correlations.....Wm. W. Graves, M. D., St. Louis
4. Hypnotism As a Therapeutic Agent...J. M. Bradley, M. D., St. Louis
5. Insanity as a Defense for Crime and the Remedy.....
.....John Punton, M. D., Kansas City
6. A Digest of Legal Discussions in This State Touching the Rights
and Liabilities of Physicians and Surgeons.
.....John Ashley, M. D., Bloomfield

MEDICAL SECTION

FIRST DAY—TUESDAY, MAY 3d, 1910.

AFTERNOON SESSION—2:00 to 5:00 O'CLOCK.

1. Enuresis.....C. A. Revelle, M. D., New Florence
2. Life Insurance Examinations..George W. Goins, M. D., Breckenridge
3. Malarial Infection and Childhood...J. H. Timberman, M. D., Marston
4. The Recognition of Lung Tuberculosis.....
.....O. H. Brown, M. D., St. Louis
5. Clinical Deductions in the Study of Tuberculosis.....
.....William Porter, M. D., St. Louis
6. The Concentration of Bacilli in Tuberculous Sputum.....
.....William K. Trimble, M. D., Kansas City
7. The Civic Responsibilities of the Doctor in the Tuberculosis
Problem.....N. P. Wood, M. D., Independence
8. Conservation by the X-Ray.....W. L. Brosius, M. D., Gallatin

SECOND DAY—WEDNESDAY, MAY 4th, 1910.

AFTERNOON SESSION—2:00 to 5:00 O'CLOCK.

1. Visceral Syphilis.....William Engelbach, M. D., St. Louis
2. Problems Offered by Dermatoses Coexisting with or Erroneously
Ascribed to Syphilis.....Joseph Grindon, M. D., St. Louis
3. The Practical Importance of the Wassermann Reaction.....
.....John W. Marchildon, M. D., St. Louis
4. Colica Mucosa.....E. H. Thraillkill, M. D., Kansas City
5. Tuberculin Therapy.....Geo. C. Crandall, M. D., St. Louis
6. The General Practitioner and Affections of the Nose and Throat..
.....E. H. Miller, M. D., Liberty
7. Psychotherapy vs. Eddyism.....R. Willman, M. D., St. Joseph

SURGICAL SECTION

Commercial Club

FIRST DAY—TUESDAY, MAY 3d, 1910.

AFTERNOON SESSION—2:00 O'CLOCK.

1. What is the Best Treatment for Acute Spreading Peritonitis?....
.....H. S. Crossen, M. D., St. Louis
2. Operations for the Cure of the More Severe Types of Uncompl-
icated Lacerations of the Pelvic Floor.....
.....Howard Hill, M. D., Kansas City

3. Vesico-Vaginal Fistula.....R. F. Amyx, M. D., St. Louis
4. Resection of the Large Intestine for Malignant Disease.....
.....C. M. Nicholson, M. D., St. Louis
5. Cases Illustrating Some Points in the Surgery of the Large
Bowel.....John Young Brown, M. D., St. Louis
6. Membranous Periccolitis.....Jabez N. Jackson, M. D., Kansas City
7. The Appendix Stump.....M. G. Seelig, M. D., St. Louis
8. Intestinal Obstruction.....O. Beverly Campbell, M. D., St. Joseph
9. Intestinal Obstruction from Appendiceal Adhesions.....
.....C. R. Dudley, M. D., St. Louis
10. Rupture of the Intestine from Abdominal Traumatism.....
.....H. P. Kuhn, M. D., Kansas City
11. Myomectomy for Uterine Fibroids...W. J. Frick, M. D., Kansas City
12. Review of the Literature on Post-Operative Phlebitis.....
.....W. A. Clark, M. D., Jefferson City

SECOND DAY—WEDNESDAY, MAY 4th, 1910.

AFTERNOON SESSION—2:00 O'CLOCK.

1. Cocaine Anesthesia in Herniotomy.....
.....Cortez F. Enloe, M. D., Jefferson City
2. Anomalies of the Inguinal Canal.....
.....Wm. A. McCandless, M. D., St. Louis
3. Paget's Disease of the Nipple, With Report of an Interesting
Case.....Ernst Jonas, M. D., St. Louis
4. Bladder Stone.....Ernest G. Mark, M. D., Kansas City
5. The Technique of Immediate Closure of the Bladder Following
Suprapubic Cystotomy.....C. E. Burford, M. D., St. Louis
6. Prostatectomy Without Opening the Bladder, by the Perineal
Route, with Immediate Suture.....
.....Arthur E. Hertzler, M. D., Kansas City
7. Carcinoma of the Penis.....W. E. Leighton, M. D., St. Louis
8. Estheomine: Report of a Case, With Exhibition of Photographs.
.....C. L. Castle, M. D., Kansas City
9. Bursitis.....J. F. Binnie, M. D., Kansas City
10. The Surgical Treatment of Bone Tuberculosis in the Adult.....
.....Alexander E. Horwitz, M. D., St. Louis
11. Osteophytes of the Os Calcis.....J. D. Griffith, M. D., Kansas City
12. Further Experience With the Internal Splint in the Treatment
of Fractures.....Herman E. Pearse, M. D., Kansas City
13. Isolated Fractures of the Greater Tuberosity of the Humerus....
.....E. P. Porterfield, M. D., St. Louis
14. The Bladder in Inguinal and Femoral Herniæ.....
.....W. T. Coughlin, M. D., St. Louis

EYE, EAR, NOSE AND THROAT SECTION

Committee Room—Second Floor

FIRST DAY—TUESDAY, MAY 3d, 1910.

AFTERNOON SESSION—2:00 O'CLOCK.

1. A Suggestion in the Treatment of Trachoma.....
.....E. T. Hornback, M. D., Hannibal
- Discussion opened by John C. Faris, M. D., Caruthersville.

2. Suppurative Ethmoiditis.....J. D. Pifer, M. D., Joplin
3. The Combined Effect of Dionin and Eserin in the Treatment of
Chronic Glaucoma.....W. A. Camp, M. D., Springfield
Discussion opened by B. E. Fryer, M. D., Kansas City.
4. Surgery of the Nasal Septum.....W. D. Black, M. D., St. Louis
5. Otitic Cerebral Abscess with Rare Ocular Symptoms.....
.....Carl Barck, M. D., St. Louis
6. Conservatism in Acute Mastoiditis.....
.....Fayette C. Ewing, M. D., St. Louis
7. Lantern Demonstration of Pathological Specimens of the Middle
Ear.....L. K. Guggenheim, M. D., St. Louis
8. Leprosy, as Seen at the San Lazores Hospital of Havana.....
.....F. B. Tiffany, M. D., Kansas City
9. Symptoms Indicating Surgical Operation for the Radical Relief
of Deafness from Chronic Catarrh.....
.....R. Barclay, M. D., St. Louis

MISSOURI SOCIETY of MEDICAL SECRETARIES

ASSEMBLY HALL.

FIRST DAY—TUESDAY, MAY 3d, 1910.

AFTERNOON SESSION—4:30 O'CLOCK.

The Society of County Secretaries will meet on Tuesday afternoon, May 3d, at 4:30. Dr. Frederick R. Green, Assistant to the General Secretary of the American Medical Association, will be present and deliver an address. Other papers on the program are:

What Should County Societies Do with Advertising Doctors? By Dr. Bert B. Parrish, Kirksville, Mo.

Some of the Duties of the County Secretary. By Dr. E. L. Stewart, Kansas City, Mo.

The Young Men in the Society; How to Interest Them. By Dr. J. L. Burke, Laclede, Mo.

A six o'clock dinner will be served at the Commercial Club.

Questions to be answered for the information of the committee on public policy and legislation, that statistics may be collected and form the basis of a plan to improve the material welfare of the members. This information is to supplement the data sent by county secretaries recently.

Age?.....

Single, married or widowed?.....

How many years have you been in practice?.....

What has been your average income per year during the past five years?.....

Do you practice general medicine?.....

Do you limit your practice to a specialty? If so, what specialty?.....
.....

Do you own your own home?.....

Is your home encumbered?..... To what amount?.....

Are you indebted otherwise?..... To what amount?.....

What are you worth financially?.....

What educational advantages have your children enjoyed?.....
.....

Have you been a defendant in a malpractice suit?.....

What was the outcome of the suit?.....

COUNTY SOCIETY NOTES

CASS COUNTY MEDICAL SOCIETY.

The regular meeting of the Cass County Medical Society was held in the "Rest Room" in the Court House, Harrisonville, Mo., April 7th. The following members were present: Drs. H. A. Brierly, H. S. Crawford, A. R. Elder, H. Jerard, M. P. Overholser, R. D. Ramey, J. S. Triplett.

Dr. A. W. McAlester, Secretary State Association, was present and read a paper on "Trachoma." His paper was of very practical value to the country practitioner, as it was along the line of treatment that could be carried out in our offices. All of the members present took part in the discussion of the paper.

The quiz, "Surgery of Chest Wall," by Dr. M. P. Overholser, was well prepared and thorough. The members present were able to get a great many good ideas and an excellent review on this subject. This was the feature of the post-graduate work that the society is taking up.

At the next meeting, June 2d, Dr. C. L. Allen, a veterinarian, will read a paper on "Bovine Tuberculosis." The society is taking active means to look after public sanitation, reports on vital statistics, quarantine regulations, and elimination of the house fly, by asking the appointment of an executive committee from the citizens health committee, to meet once each month to discuss and publish reports on vital statistics and questions of public health.—H. S. CRAWFORD, M. D., Secretary.

HOWARD COUNTY MEDICAL SOCIETY.

Howard County Medical Society met at Fayette on April 1st. The following members were present: Drs. Lewis, Lee, Wright, Bonham, Kitchens, W. R. Hawkins, Burgwin, Moore and Watts.

Dr. W. R. Hawkins was elected alternate delegate to the state meeting at Hannibal.

Drs. Moore and Thompson, for the Committee on Chiropractics, reported that nothing could be done until the case now in the Supreme Court was decided.

A letter from Dr. W. C. Abbott was read concerning the Mann bill in the United States Senate, and the society unanimously resolved to oppose its passage. The secretary was instructed to so inform our representatives and senators.

Drs. Lee and Smith reported two cases of smallpox and several cases of scarlatina and rubeola. The cases were all well quarantined and no danger of an epidemic was anticipated. The city council met with the board of health and ordered that a penalty be assessed against any doctor who failed to report contagious diseases.

The secretary spoke of the coming meeting of the State Association at Hannibal and urged that a large delegation from Howard County Society attend.

The next meeting will be held at Glasgow, June 3d.—C. W. WATTS, Reporter.

JASPER COUNTY MEDICAL SOCIETY.

At a recent meeting of the Jasper County Medical Society, the following officers were elected for the year 1910: President, Dr. C. C. Cummings, Joplin; vice-president, Dr. M. E. Steele, Carthage; secretary, Dr. Mary L. Mack, Joplin; treasurer, Dr. A. B. Freeman, Joplin; delegate, Dr. R. M. James, Joplin; alternate, Dr. J. M. Clark, Cartersville; board of censors, Dr. R. L. Neff, Dr. A. B. Clark, Dr. M. H. Langan.—MARY L. MACK, M. D., Secretary.

MONTGOMERY COUNTY MEDICAL SOCIETY.

The Montgomery County Medical Society met at the office of Dr. Muns, in Montgomery City, April 13th, Dr. Revelle presiding. Those present were Drs. C. A. Revelle, D. O. Hudson, E. W. Tinsley, J. L. Jones, David Nowlin, G. E. Muns, W. M. Wheeler and B. F. Menefee.

A measure known as the Mann bill, introduced in the U. S. Senate by Senator Cullom, of Illinois, was read by the secretary and after some discussion was condemned by unanimous vote and the secretary instructed to communicate this action of the society to Representative Champ Clark and solicit his opposition to the passage of the bill. Dr. Nowlin's talk on surgery for the country doctor was short and to the point and brought out some practical thoughts.

Application of Dr. B. F. Menefee for membership was received and acted on favorably.

On motion it was determined to hold our next meeting at Mineola on Tuesday, June 8, and that the meeting should be purely social in character. The members are to take their families and friends and spend the day in fishing, boat-riding and bathing.

Our society now numbers only ten, but they are earnest and enthusiastic and are getting much benefit from our organization, and we feel that those of the profession who persist in remaining out of the society are depriving themselves of advantages which they should be enjoying.—W. M. WHEELER, M. D., Secretary.

NODAWAY COUNTY MEDICAL SOCIETY.

Nodaway County Medical Society met in regular session on April 12th, at Maryville, with the following members present: Drs. Todd, Anthony, Wallis, Jr., Dean, Crowson, Wells, Barnet and Fisher. The program was a discussion of typhoid fever. Dr. Crowson gave an interesting talk on diagnosis. Dr. Todd brought out many good things on complications and sequelæ, after which all present took an interesting and profitable part in the general discussion.

Drs. Wells and Wallis, Jr., outlined a serious case of contusions, lacerations and fractured skull due to the work of a stalk cutter and runaway team. Dr. Anthony presented an interesting case of gunshot wound.

Many interesting and valuable points were brought out in the regular program and the general discussion so that every member present went away feeling that he had been made a better doctor. It was one of the best meetings we have had in a long time.

The society meets again on May 10th and will take dinner together at the Linville Hotel. A good social time will be had, after which the general subject of fractures and dislocations will be discussed.